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ABSTRACT

The purposes of this conference were to clarify the role of health educators, to identify institutional responsibilities in credentialing health educators, to examine the credentialing process as it applies to the preparation of health educators, and to establish criteria for the entry-level health educator. Participants, health educators from various practice settings, were also asked to consider the responsibilities of the health educator in relation to healthy people. Brief summaries are presented of the discussion groups' comments on: (1) the role of the generic, entry-level health educator; (2) certification of the health educator; (3) program accreditation; (4) institutional and personal implications of role delineation and credentialing; and (6) health educators and disease prevention/health promotion objectives for the United States. Speeches presented at the conference addressed: (1) an historical perspective on professional preparation; (2) national objectives in disease prevention/health promotion (3) regulatory programs governing the certification of health professionals; (4) the progress of the Role Delineation Project, initiated to promote a unified approach by health professionals to their duties and responsibilities; (5) certification of community health educators; (6) certification of health educators in medical care; (7) implications of certification and accreditation standards for school health education and for institutions and programs; and (8) recommendations for future action, options, and opportunities. Recommendations generated by the three-day conference are included along with background papers and events leading to this conference. (JD)

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ED209215

National Conference for Institutions Preparing Health Educators

February 5-7, 1981
Birmingham, Alabama

Proceedings

U.S. DEPARTMENT OF EDUCATION
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U.S. Department of Health and Human Services

Public Health Service
Office of Disease Prevention and Health Promotion
Office of Health Information, Health Promotion, and Physical Fitness and Sports Medicine

DHHS Publication No. 81-50171

SP 019 040

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Office of Disease Prevention and Health Promotion
J. Michael McGinnis, M.D., Deputy Assistant Secretary for Health

Office of Health Information, Health Promotion, and Physical Fitness and Sports Medicine
Lawrence W. Green, Dr.P.H., Director

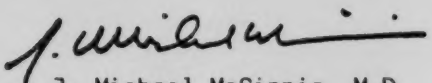
Foreword

The National Conference for Institutions Preparing Health Educators represents an important milestone for academic leaders in health education, and I am pleased that the Public Health Service has played a role in sponsoring it. Two hundred fifty conferees representing nearly 100 training programs affirmed their commitment to preparing practitioners to make the best possible contribution to programs directed toward the goals and objectives of Healthy People, the Surgeon General's report on Health Promotion and Disease Prevention, and Promoting Health/Preventing Disease: Objectives for the Nation.

Conference deliberations centered on credentialing and curriculum issues related to the national Role Delineation Project for health education currently being conducted under contract from the Public Health Service's Bureau of Health Professions to identify generic functions and core competencies for health educators working in schools, clinical settings, worksites, and the community. Out of this thoughtful discussion and debate came recommendations for future project directions, the National Task Force for the Preparation and Practice of Health Educators, and their own training programs in colleges and universities. In addition to these recommendations, the conference's proceedings contain papers addressed to such key topics as the competencies needed in the major practice settings now and in the future and the mechanisms through which schools can meet their responsibility to the public in providing this preparation.

It is clear that attainment of our national goals and objectives is dependent upon effective efforts to motivate people to enhance their own health-related practices. While the success of these efforts requires the participation of a variety of professionals, indeed, of every citizen, the responsibility for leadership lies with the health educator.

These proceedings should be both a stimulus and a guide to further growth in the potential for that leadership, as it emerges through individual academic programs as well as at the national level.



J. Michael McGinnis, M.D.
Deputy Assistant Secretary for Health
and Assistant Surgeon General

Preface

If it had been suggested ten years ago that a conference be held among health educators from all practice settings for any purpose, let alone to discuss the role of a generic health educator, it would not have happened. There were exceptions, of course, but health educators in school, community, and medical care settings simply did not communicate with one another. Their preparation, functions, and even language usage were significantly different.

What, then, were the factors that made meeting in Birmingham not only attractive but mandatory? I will attempt here to identify some of the more significant of these factors. The rising costs of our health care system together with an ever-increasing number of health problems have increased the prominence of health promotion and disease prevention in national thinking. That is, if spending more money to treat illness is not a solution to achieving good health, perhaps the answer lies in assigning greater resources to preventing disease and promoting wellness.

The structure of the National Coalition of Health Education Organizations illustrates the fact that the health education profession has grown up in several different ways, under several different auspices: Within the coalition are eight different national organizations with varying areas of concentration, all committed to health education. As a consequence, a health educator can belong to one of these organizations without communicating with members of the other organizations. With communication thus limited, understanding is next to impossible. At the same time that health educators continued to work separately, without a unified approach to health education, professionals in other disciplines began to advertise their involvement in the field, without the benefit of preparation in health education. Since 1960 an increase of over 200 percent in the number of professional preparation programs has been accompanied by little attempt at standardization of preparation, quality control, or placement of graduates. The availability of financial

resources through emphasis on promotion and prevention, the proliferation of preparation programs without unifying factors, and the intrusion of unprepared practitioners into the field combined to provide incentive for health educators to "get their act together."

In the summer of 1978, a small group representing all practice settings met and agreed to discuss these issues openly and to decide upon a course of action. As a result, the Division of Associated Health Professions, U.S. Bureau of Health Manpower, sponsored a meeting of a representative sampling of health educators February 15-17, 1978, in Bethesda, Maryland. Participants in the Bethesda conference discovered considerably more likenesses than differences in the preparation and practice of health educators. Upon the recommendation of this conference, the National Task Force on the Professional Preparation and Practice of Health Educators was established and charged with developing a plan of action leading to a credentialing program for the entire field of health education. The National Conference for Institutions Preparing Health Educators, held February 5-7, 1981, in Birmingham, Alabama, was a significant step in this plan.

Credentialing is an umbrella term for the mechanisms used by a field of practice to designate to both provider and consumer type and quality of practitioner. Among these mechanisms are accreditation, licensure, certification, and/or registration. Any or all of these mechanisms may be part of the credentialing process, but the deecision of whether to credential itself and, if so, which mechanisms to use is up to the field of practice. Although the health education profession has strongly supported the suggestion of a credentialing system, it has not agreed upon which mechanisms to include in that system.

In October 1978, the National Task Force was successful in obtaining funds from the Bureau of Health Manpower (now the Bureau of Health Professions) to support the first phase of its task--initial role specification. In the same month the Role Delineation Advisory Committee (RDAC)--comprising representatives of the eight national health

education organizations, a chairperson, and a consumer representative--was established. The committee employed a director of the Role Delineation Project in January 1979, who began to work with the Role Delineation Working Committee (RDWC) to develop the initial role specification document. Completed in January 1980, this document was disseminated to all professional preparation programs in the United States through presentations at local, state, regional, and national meetings and was published in full in the July 1980 issue of Focal Points, jointly released by the Bureau of Health Education and the Office of Health Information, Health Promotion, and Physical Fitness and Sports Medicine.

In May 1980, the National Center for Health Education was awarded a contract to complete the second phase of the Role Delineation Project--"Role Verification and Refinement." The Role Verification Working Committee (RVWC) is presently conducting a survey to determine whether the initial role specification statement accurately reflects the current situation in various practice settings. This phase of the project is to be completed by August 1981.

Completion of the remaining phases of the project depends upon funding. These phases include Phase III: Preparation of Educational Resource Document; Phase IV: Development of Self-Assessment Instruments for Practitioners; and Phase V: Development of Continuing Competency Materials. With the role delineation activities in process, the National Task Force gave consideration to a meeting of representatives of the professional preparation institutions in an effort to involve these institutions more closely in the process of determining the role of the health educator. The Birmingham conference was planned to coincide with the meeting of the Verification Committee to allow the institutions maximum contribution to defining the role of the health educator. The National Conference Planning Committee, formed in July 1980, conducted a needs assessment survey of all the health education professional preparation institutions in the United States. These institutions were asked to indicate their interest in and ability to provide representatives to such a conference, their familiarity with

role delineation issues, and other issues in health education of importance to them. Within two weeks, over 75 percent of the institutions surveyed responded favorably to the suggestion of a national conference on role delineation.

The conference was scheduled for February 1981 under the sponsorship of the National Task Force; the Office of Health Information, Health Promotion, and Physical Fitness and Sports Medicine of the U.S. Department of Health and Human Services; the Bureau of Health Education (now part of the Center for Health Promotion and Education), USDHHS; the Office of Comprehensive School Health, U.S. Department of Education; the Bureau of Health Professions, USDHHS; the National Center for Health Education; the Coalition of National Health Education Organizations; and Eta Sigma Gamma. The host for the national conference was the School of Education, University of Alabama in Birmingham.

The Planning Committee set the following conference goals:

- To identify institutional responsibilities and options in credentialing health educators
- To examine the credentialing process as it applies to the preparation of health educators and to establish criteria for the entry-level health educator
- To identify the responsibilities of the health educator in relation to Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention (1979) and Promoting Health/Presenting Disease: Objectives for the Nation (1980)
- To recommend to the National Task Force mechanisms for credentialing health educators.

A significant number of individuals representing most of the institutions surveyed attended the conference in addition to representatives of local, State, and Federal government agencies as well as international organizations. It was clear that timing of this conference was right: Professional preparation institutions were ready to talk about role delineation and its implications for credentialing. The conference

was designed to provide ample opportunity for participants to contribute to the initial role specification statement, to comment on the verification process strategy, and to comment on both whether the credentialing initiative should continue and what part institutions should take in the process.

In planning the conference, the committee tried to strike a balance between substantive presentations and group discussion to allow maximum contribution by the participants to the role delineation and credentialing processes.

The six major recommendations that evolved from the conference are as follows:

- That the Role Delineation Project continue
- That the role specification statement have a mission statement and a preamble preceding discussion of the role itself
- That the verified and refined role specification statement represent accurately the role of the entry-level health educator
- That the preferred health education credentialing mechanism be identified as voluntary certification
- That communication and marketing be increased within and outside the health education profession
- That the feasibility and desirability of a single national organization to represent health educators be studied.

These recommendations constitute an agenda for professional discussion for the next several years.

I am confident that the Birmingham conference will prove to be a significant milestone in the progress of the health education profession and of its members. I urge you to read these proceedings critically, to continue to contribute to the role delineation process, and to discuss these issues actively with your faculty colleagues, students, and practitioners in your area.

I wish to acknowledge the invaluable contributions to the success of this conference made by the Office of Health Information, Health Promotion, and Physical Fitness and Sports Medicine; the Center for Health Promotion and Education, Centers for Disease Control; Ball State University; the University of Alabama in Birmingham; the members of the Planning Committee, particularly Dr. Cleary, Dr. Henderson, Mr. Ogden, and Dr. Mullen; and Mr. Bernard Glassman and Ms. Diane McDonough of JRB Associates.

These proceedings are dedicated to those who made the Birmingham conference possible, to conference participants, and to all health education professionals.

Warren E. Schaller

Warren E. Schaller, H.S.D., Chairperson
National Conference Planning Committee
National Task Force on the
Professional Preparation and
Practice of Health Educators

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2	Loren B. Bensley, Jr. Central Michigan University	Debra Leigh Sutton Ball State University
3	Peter A. Cortese U.S. Department of Education	Elizabeth A. Lee American Hospital Association
4	Herb Jones Ball State University	Sheila Gorman Columbia University
5	Elena M. Sliepcevich Southern Illinois University	Elaine M. Vitello Southern Illinois University
6	Alan C. Henderson National Center for Health Education	Sharon Lee Zajac National Conference Planning Committee
7	Marshall W. Kreuter University of Utah	Lorraine Henke Prince George's County, Maryland, Public Schools
8	Leonard E. Tritsch Oregon Department of Education	Patricia D. Mullen U.S. Department of Health and Human Services
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10	Anna W. Skiff USPHS Hospital Staten Island, New York	Stephen D. Assenmacher Hartland, Michigan, Consolidated Schools
11	Helen P. Cleary University of Massachusetts	Elizabeth Bernheimer University of Nevada
12	Robert H. Conn D.C. Department of Human Services	Laura Anderson Berkeley, California, City Health Department
13	Betty Mathews University of Washington	Marion B. Pollock California State University
14	Helen S. Ross San Jose State University	Charles R. Carroll Ball State University

Group Number	Leader	Recorder
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16	Joan M. Wolle Maryland State Department of Health and Mental Hygiene	Sue Rexroat Macomb, Illinois, Senior High School
17	Deborah V. McIntosh National Center for Health Education	John J. Burt University of Maryland
18	Beverly Ware Ford Motor Company	John P. Allegrante Columbia University
19	Chet E. Bradley Wisconsin Department of Public Instruction	Cheryl Alexander Indianapolis, Indiana, Division of Public Health
20	Jane Zapka University of Massachusetts	Maureen E. Sullivan USDHHS Bureau of Health Professions

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Agenda

National Conference for Institutions Preparing Health Educators

Hilton Hotel – Birmingham, Alabama
February 5-7, 1981

Role Delineation: Implications for Credentialing

AGENDA

Thursday, February 5

6:00 p.m.
Foyer

REGISTRATION

7:30-9:00
Heritage I

FIRST GENERAL SESSION

PRESIDING: Warren E. Schaller, H.S.D., Chairman and Professor, Department of Physiology and Health Science, Ball State University

WELCOME: Thomas K. Hearn, Jr., Ph.D., Vice President for University College, University of Alabama in Birmingham

C. W. Scott, Jr., M.D., Deputy Dean, School of Medicine, University of Alabama in Birmingham

Milly Cowles, Ph.D., Dean, School of Education, University of Alabama in Birmingham

CONFERENCE OVERVIEW: Warren Schaller

Professional Preparation: An Historical Perspective: William H. Creswell, Ed.D., Professor of Health Education, University of Illinois

The Objectives for the Nation in Disease Prevention and Health Promotion: A Challenge to Health Education Training: Lawrence W. Green, Dr.P.H., Director, Office of Health Information, Health Promotion, and Physical Fitness and Sports Medicine, U.S. Department of Health and Human Services

9:00
Alabama Room

SOCIAL
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Friday, February 6

7:30 a.m. Foyer	Continental Breakfast
8:30 Heritage I	SECOND GENERAL SESSION CONFERENCE ARRANGEMENTS: Mabel C. Robinson, Ed.D., Assistant Dean, School of Education, University of Alabama in Birmingham
8:45	Conference Design and Anticipated Outcomes
9:00	Credentialing for the 1980s: Raymond D. Salman, Ed.D., Director of Professional Licensing, New York State Education Department
9:45	Perspectives on Role Delineation: Alan C. Henderson, Dr.P.H., Director, Role Delineation Project, National Center for Health Education
10:45 Foyer	Break
10:30 Heritage I	Credentialing: Implications for Health Educators: Panel -- Raymond W. Carlaw, Dr.P.H., Director, Program in Health Education, University of Minnesota; Laura C. Keranen, Lecturer, School of Public Health, University of California, Berkeley; Marian V. Hamburg, Ed.D., Professor and Chairperson, Department of Health Education, New York University
11:15	DISCUSSION GROUP INSTRUCTIONS
11:30	FIRST DISCUSSION GROUP SESSION Role Delineation and Credentialing
12:30 p.m. Foyer	Box Lunch
2:00	SECOND DISCUSSION GROUP SESSION Continuation of morning session
4:00 Heritage I	DISCUSSION GROUP SUMMARY Comments and Directions
5:00	ADJOURNMENT
5:30 Alabama Room	Social Hour Sponsored by Eta Sigma Gamma

Saturday, February 7

7:30 a.m. Foyer	Continental Breakfast
8:30 Heritage I	THIRD GENERAL SESSION Credentialing: Implications for Institutions and Programs: Lee Holder, Ph.D., Dean, College of Community and Allied Health Professions, The University of Tennessee Center for the Health Sciences
9:30	THIRD DISCUSSION GROUP SESSION Personal and Institutional Implications of Credentialing
11:30 Heritage I	Lunch Options and Opportunities: Recommendations for Future Action: Scott K. Simonds, Dr.P.H., Professor of Health Education, University of Michigan
1:00 p.m.	FOURTH DISCUSSION GROUP SESSION Development of Recommendations for National Task Force
3:00 Heritage I	DISCUSSION GROUP REPORTS Response by the National Task Force: Helen P. Cleary, D.Sc., Associate Professor, University of Massachusetts Medical School
4:30	ADJOURNMENT

Discussion Group Summaries

Discussion Group Summaries

Introduction

Participants in the Birmingham conference expressed both enthusiam about their progress and support for continuing the Role Delineation Project. The section of these proceedings entitled "Recommendations of the Conference" demonstrates the consensus of the participants on several important issues. In contrast, this section presents summaries of group discussions that pinpoint those issues requiring further debate.

For example, the issue of balance between process and content appears to be basic to different conceptualizations of the role of the health educator among the professors of health education. This is probably the major issue that must be resolved in the curriculum development phase of the Role Delineation Project.

It is important to identify areas of both agreement and disagreement so that members of the profession can better understand the positions of their colleagues. These topics are appropriate bases for discussion at local, regional, and national meetings of professional organizations and for articles in professional journals. Moreover, airing differences is the best approach to resolving them, wherever resolution is possible. And despite the variety of views expressed in Birmingham, it is clear from both the findings of the Bethesda conference and the recommendations of this conference that commonalities are greater than differences among branches of the health education profession.

Each of the 20 discussion groups met four times. Specific questions were posed for consideration during each session. However, since other, related issues were raised during the discussion of these

questions, we have reported the groups' comments according to the general topic. Those areas of consideration are:

I. The role of the generic, entry-level health educator (as published in July 1980 Focal Points)

II. Certification of the health educator

III. Program accreditation

IV. Institutional implications of role delineation and credentialing

V. Personal implications of role delineation and credentialing

VI. Health educators and disease prevention/health promotion objectives for the Nation

VII. Miscellaneous.

The charge for discussion in Session 4 was to formulate recommendations. Since the outcome of that session is presented in the Conference Recommendations section of these proceedings, we have not included a report of Session 4 in this section.

The differences in tone and content of participants' comments are essential to understanding the current status of the health education profession as seen by its members. In an attempt to preserve these rich data, we have selected representative comments for reporting and have kept editing at a minimum.

Helen P. Cleary, D.Sc.
Associate Professor
University of Massachusetts
Medical School

Phyllis G. Ensor, Ph.D.
Associate Professor
Towson State University

Questions Discussed

Sessions 1 and 2:

(a) Do the responsibilities and functions described in the role delineation documents accurately and adequately describe the role of a generic (i.e., all settings) entry-level health educator?

(b) Do the skills and knowledge described in the role delineation document accurately and adequately describe the role?

(c) How can role delineation for health educators be linked more closely with national health goals, for example, as identified in Healthy People?

Session 3:

(a) What are the current responsibilities of your training program for the credentialing of your graduates?

(b) What options or opportunities do you see for your institution and other institutions in dealing with credentialing of health educators?

(c) Which factors will facilitate and which factors will hinder individual institutions or groups of institutions in dealing with the credentialing of health educators?

(d) What problems do you see in connection with accreditation of academic health education programs? What solutions do you see for these problems?

(e) What are the personal responsibilities to the individual health educator or teacher of health educators in relation to credentialing?

(f) What is the responsibility of training institutions to national goals?

Session 4:

(a) Do we want to recommend efforts be continued to develop a credentialing system for health educators? If not, why not?

(b) What specific directions should the credentialing process take in the immediate future?

(c) What providers should be considered in the planning of next steps?

(d) How should the Task Force relate to, communicate with, or involve training institutions?

(e) Are there sources of funding that should be considered for next steps?

I. THE ROLE OF THE GENERIC, ENTRY-LEVEL HEALTH EDUCATOR (AS PUBLISHED IN JULY 1980 FOCAL POINTS)

There were more comments about the draft role document than any other topic discussed at the conference. Detailed suggestions such as changes in wording are not included here. These have been submitted to the Role Verification Working Committee.

A. General Comments

Appropriateness of "Entry Level" Across Settings

1. Almost all the responsibilities and functions are identical with those other professions would claim (e.g., communicating, administrative functions, etc.). The processes and content are largely shared with all educators, social workers, etc. What really distinguishes health educators from others?

2. The role as defined expects too much of the school health educator.

3. Some responsibilities are not pertinent to patient and school health educators, and all responsibilities are not equally important.

4. The examples refer primarily to community settings. School health educators might be better able to identify with the document if more examples pertained to education settings. Community or public health jargon increases as the document progresses.

Value of Role Delineation

1. The role delineation document could be helpful to the field, e.g.: in making the case for adequate faculty and training resources within universities and colleges; as the basis of job descriptions; in educating employers; and as a "Flexner Report" to improve the quality of health education training.

2. The role delineation document should be the basis for developing standards of practice and for a certifying examination.

Need for Advocacy

1. There is a pressing need to convey the role and functions to both employers and administrators and other decision-makers in training institutions.

2. How will the role delineation document influence employers and their hiring practices? Can it be used to encourage the hiring of trained and eventually certified health educators?

B. Additions to the Role

Frame of Reference

1. The most serious deficiencies identified in the document were: lack of a conceptual framework, specification of assumptions, and a statement of the philosophical and scientific base of practice. As it stands, the document risks being overly technical and present-oriented; it is an admixture of housekeeping and high-level responsibilities.

2. The areas of responsibility, functions, skills, and knowledge, although perhaps generally useful in beginning to delineate the role of the health educator, may be overly technical and mechanistic.

3. A glossary of terms should be included with the document. It should define terms such as planning, budget, and implementation, using examples from health education practice.

4. The role should be rewritten to focus on serving people rather than on program.

5. The role needs greater emphasis on skill development and greater specification of skills.

6. Emphasis should be on the facilitator function rather than on service delivery function.

7. The role needs to convey that health educators do not work in a vacuum but relate to and interact with a variety of social systems.

8. The role as defined seems to focus on the health educator as a transmitter of information and omits the social dynamics of the role.

9. The role does not address the issue of public accountability. It overemphasizes process skills, offers little on interpersonal skills, lacks a philosophical component, and does not address the issue of health educators as role models.

10. Professional ethics should be addressed in the role.

11. The task analysis strategy on which the role delineation is based is questioned.

Content

1. School educators were concerned that no content areas were mentioned in the document. Nowhere is there reference to health, disease, physiology, smoking, nutrition, etc. "Process" dominates. A meshing of content and process needs to occur.

2. Health education deals with health promotion and disease prevention. Neither is visible anywhere in the document. Yet this is what separates health educators from other professionals who may carry out similar functions.

3. There is no reference to the need for knowledge about the medical care/public health system.

4. There is no reference in the role to the impact of systems on the functioning of the health educator.

Supervision

1. There should be reference in the role to the need for supervision of an entry-level health educator.

2. Skills and knowledge for the entry-level health educator should include those that could be performed autonomously, i.e., without supervision.

C. Concepts Related to the Role

Entry Level

1. There is a need to provide further clarification of the term, "entry level." The definition in the initial role specification is confusing. It must be defined more precisely before one can examine areas of responsibility, functions, skills, and knowledge.

2. The role as delineated is an accurate description of a generic health educator, but it goes beyond entry level.

3. Each of the responsibilities in the role delineation document is reasonable for an entry-level health educator. However, the skills necessary to carry out these responsibilities could not possibly be acquired in a baccalaureate program.

4. There should be an indication of the degree of proficiency expected of an entry-level person in responsibilities, functions, skills, and knowledge.

5. It is difficult, if not impossible, to prepare an entry-level health educator for all settings.

Generic

1. Can there be a generic, entry-level health educator? The positions health educators have are so diverse. Would a generic educator be "a jack of all trades and a master of none"?

2. There is a common thread that "runs through" the practice of health education in all settings.

Specialization/Career Ladder

1. The concept of beginning with a generic role is acceptable. However, a mechanism needs to be established to accommodate a specialized focus in practice.

2. There is a need to categorize responsibilities, skills, and knowledge by levels of practice.

3. Does or should a Master's degree connote specialization? At this time, it is questionable whether one can differentiate between a Bachelor's and a Master's graduate in terms of knowledge and skills.

4. Consideration must be given to a professional development ladder. The requirements for the Bachelor's and Master's degrees need to be differentiated.

II. CERTIFICATION

Comments on certification of the health educator included: (a) thoughts about the process, (b) consideration of the value of certification, (c) concerns about the quality of a certification examination, (d) the cost of retraining faculty, (e) the support needed both within and outside the profession for an effective certifying process.

A. Process

1. Factors that will influence the certifying of health educators include: cost to the individual or institution; conflict with existing regulations and/or requirements of a State agency or institution; the employability of program graduates, that is, certified versus non-certified; setting standards that are valid and appropriate; dealing with lawsuits from students who do not pass the examination; the need to educate prospective employers; pressure from third-party payers; and the strength of a professional organization to facilitate the process.

2. Voluntary certification is the preferred method. After a period of experience, the health educator would be eligible to sit for the examination, which should both have a generic base (core) and provide for a specialty track. This method would eliminate the problems inherent in tying certification to graduation from a Bachelor's-level program.

3. The certifying mechanism that is or might be developed should be voluntary rather than mandated, with control, authority, and responsibility in setting standards resting with the profession. Further, it should provide for a grandfather clause.

4. A baccalaureate degree in Health Education should be required at the pre-service level before the educator is eligible for certification.

5. Since certification of health educators would be a national program, reciprocity among States is not an issue. However, since school health educators must be certified by the States in order to teach, reciprocity in this area would be desirable.

B. Value

1. Will certification assure quality in practice?

2. Will certification make the health educator more employable?

3. Will certification protect the public?

4. Is certification the "way to go" at this point in history? What are the dangers or unintended negative effects of this process?

5. Certification of the health educator is preferable to accreditation of a program. It is less expensive and easier to accomplish.

6. Some type of certification is needed. The contribution of the health educator vis-a-vis other professions must be identified and receive a stamp of approval.

7. How will certification affect liberal education courses at the baccalaureate level? Will professionalization narrow the education when openness to ideas and creativity is needed in health education?

C. Examination

1. Concerns over the certification exam include: Who does the testing? Who develops the test? What kind of test should be used, and how will skills be examined? An examination may be necessary but not sufficient in determining competency.

D. Cost

1. The cost to institutions for meeting standards for certification of graduates needs to be considered. The training

of faculty to qualify at the entry level for some of the skills and knowledge will be a major expense.

E. Support Needed

1. There is a need to educate policy-makers, employers, and consumers about certification in order to gain support.

2. An effective certifying process demands a united profession. Can or will health educators come together to support this effort?

III. PROGRAM ACCREDITATION

The discussion about accreditation was not extensive. Thoughts were expressed about: (a) program accreditation; (b) the link between accreditation and certification; (c) the value of accreditation.

A. Program Accreditation

1. A major problem with accreditation is the financial burden and the difficulty of convincing administrators that programmatic accreditation is worth the expense. For many institutions programmatic accreditation would not be acceptable.

2. If there is programmatic accreditation, it should include a large self-study component and should not be under the auspices of any one of the existing accrediting or professional organizations.

3. At the program level, recognition may be more appropriate than accreditation. Recognition by a professional association, on a voluntary basis, would be less expensive than accreditation.

4. The current programmatic accreditation process is unfair; programs in schools of public health receive accreditation if the school is accredited. Programs in non-schools of public health must go through a rigorous, time-consuming, expensive process to receive accreditation.

5. North Carolina has a voluntary registration program of graduates of "approved" schools. A school accredited by some formal body fulfills the criteria for "approved."

B. Link Between Accreditation and Certification

1. Students should be able to be certified even if the health education programs in their schools are not accredited.

2. A student should have to graduate from an accredited program before being eligible for certification.

C. Value of Accreditation

1. Program accreditation is a requirement for receipt of Federal funds.

IV. IMPLICATIONS OF ROLE DELINEATION AND CREDENTIALING FOR INSTITUTIONS

The comments on the implications for institutions of role delineation and credentialing fall into four categories: (a) institutional response to the process; (b) the effect of role delineation and credentialing on institutions; (c) institutional responsibility to health educators; (d) responsibility for the institution's health education program.

A. Institutional Response

1. There is a need to develop a specific credentialing mechanism in the field of health education that provides standards for the preparation and practice of health

educators in any practice setting. Despite considerable barriers to credentialing, once a single mechanism is developed and accepted, institutions and individuals would commit themselves to overcoming barriers such as costs in order to ensure that quality and standards in health education are being upheld.

2. Institutions may wish to avoid the issue of upgrading training of health educators. Reduced enrollment is a strong possibility for most institutions. Quality control of health education offerings has the potential for further reducing enrollment. The temptation to ignore the latter may be great for some institutions.

B. Effect of Credentialing and Role Delineation on Institutions

1. Credentialing may force training institutions to develop stronger programs or, if they are unable to do so, to close shop. Therefore, credentialing should be entirely voluntary, with no stigma attached to institutions that cannot live up to prescribed standards.

2. The credentialing process will upgrade the quality of programs and may force marginal programs to terminate.

3. Most Bachelor's-level programs are weak in the behavioral sciences. Many faculty in departments of health education are not trained to teach process skills. Linkages with other departments (an interdisciplinary faculty) are one way to deal with this issue.

C. Institutional Responsibility to Health Education Practitioners

1. Participate in (promoting, sponsoring, cosponsoring) continuing education programs for the practitioner, and monitor the quality with rigor.

2. Sponsor regional meetings to encourage more participation and discussion of the role delineation and credentialing processes.

3. Organize statewide committees of all institutions to assess options available to students, e.g., transfer of courses, the consortium approach, etc. These mechanisms can make use of scarce resources and provide content or skill training lacking in a given program.

D. Responsibility for the Institution's Health Education Program

1. Consider the quality of their programs and teachers. Faculty must be qualified.

2. Not overextend their resources to develop a community health education program, and thereby destroy a good school-oriented program.

3. Look at program honestly (difficult) to determine whether they are preparing health educators for settings in which they are really needed.

4. Develop quality assurance mechanisms including advisory boards, use of existing standards and guidelines, careful selection of field supervisors.

5. Begin to use the role delineation document in a positive way, e.g., as a curriculum guide, while the processes of verification and adoption are going on at the national level.

6. Compare current offerings in health education with the requirements of role delineation.

7. Develop a pilot curriculum for skills and knowledge required by role delineation and for the generic health educator.

8. Conduct faculty in-service training; discuss options and opportunities related to credentialing.

9. Share experiences in gearing up for credentialing with other institutions.

10. Advocate the credentialing process with State certifying and standard-setting agencies.

11. Determine the critical faculty mass needed to train an entry-level health educator.

V. PERSONAL IMPLICATIONS OF ROLE DELINEATION AND CREDENTIALING

The comments on the personal implications of role delineation and credentialing fell into two categories: (a) the individual's responsibility to work with others; (b) the individual's responsibility to improve and/or update his/her skills and knowledge.

A. Individual's Responsibility to Work With Others

1. All attending the conference must share with faculty and administration in their universities what occurred at the conference, what has been done, and what has yet to be accomplished in role delineation and credentialing.

2. Work with administrators to remove barriers such as restricting course offerings that may be essential for certification or needed for continuing education.

3. Organize state and/or local groups to discuss, promote, and implement credentialing issues.

B. Individual Initiative

1. Faculty should have a positive attitude regarding credentialing, emphasizing cooperation, compromise, and communication.

2. Faculty have a responsibility to meet the standards, as demanded, in the future and to revise curriculum accordingly.

3. Individual health educators must continue to grow professionally. Continuing education is one mechanism for professional growth.

4. The role delineation document can be used for self- and departmental review. It requires that everyone do some rethinking (we are not critical enough of ourselves).

5. Faculty have a responsibility to keep up to date, i.e., upgrade their skills and knowledge especially as these relate to process.

VI. DISEASE PREVENTION/HEALTH PROMOTION OBJECTIVES FOR THE NATION

Discussion on Objectives for the Nation included the following categories: (a) the value of the document; (b) the relationship of the document to role delineation; (c) the effect of the document on training programs; (d) the contribution of the health educator to meeting the objectives.

A. Value of the Document

1. Promoting Health, Preventing Disease: Objectives for the Nation should be used to determine pertinent content of the generic, entry-level health educator needs. The information in this document would also be useful in determining the types of continuing education needed by

practicing health educators. This document and Healthy People provide the content the role delineation document lacks.

2. Healthy People can provide leverage for creation of priorities for course requirements for health educators, undergraduates, and graduates and for continuing education courses. Some, however, preferred local autonomy in deciding on priorities for courses.

3. Objectives for the Nation can be used to build linkages between health administration, health promotion, and health education. The needs identified in this document justify the work of the health educator.

B. Relationship to Role Delineation

1. The areas of responsibility in the role delineation document should be preceded by a statement that indicates the application of these responsibilities to the national health goals. Also, the examples in the document should relate to the topics included in the national health goals.

2. Role delineation efforts integrate logically with the thrust to meet national health goals by 1990.

C. Effect on Training Programs

1. The Objectives for the Nation are categorical. Is it wise to train health educators on categorical lines, losing sight of our overall goals and mission? Health is a generic, not a categorical, concept. There is or should be more to health education than striving for reduction of morbidity and mortality from specific diseases.

2. Institutions training health educators need to focus on the 15 areas in Objectives for the Nation, perhaps eliminating some topics in our current training programs.

D. The Health Educator's Contribution

1. Health educators have a definite contribution to make to the accomplishment of the Objectives for the Nation. Therefore, the health educator should be equipped to contribute to these goals and to health promotion (beyond the medical model).

2. It is important to define realistically the health educator's contribution to the national health goals.

3. The role school health educators can play in meeting the national health goals needs to be articulated.

VII. MISCELLANEOUS

A number of comments made at the conference, although related to the major issues discussed, do not fit under the headings in this summary. These include important ideas covering a wide range of issues. We have reported them separately as follows: (a) marketing the credentialing process; (b) continuing education; (c) ethics; (d) academic freedom; (e) curriculum issues; (f) linkages among branches of the profession; (g) updating the role; (h) professional control; (i) international effect of the role; (j) value of credentialing; (k) teacher certification and role delineation.

A. Marketing the Credentialing Process

1. With a new generation of leaders who are ready to see what we share rather than how we differ within the profession, the time seems ripe for uniting health educators. However, the major task will be to "market" the concept of a

consolidated profession, role delineation, and credentialing to the members of our profession. This "marketing" must receive special attention. It should be made the responsibility of a special committee charged to develop and coordinate strategies for this matter.

B. Continuing Education

1. There is a need for a system of continuing education available to all health educators. Credentialing will force continuing education for practitioners and academicians.

C. Ethics

1. How do we ensure that the practice of health education is ethical?

D. Academic Freedom

1. There is a need to allow for regional and institutional discretion and freedom of individual faculty members to make judgments about preparation needs within the overall missions of their schools and departments.

2. Is there a danger of violation of academic freedom by promoting role delineation, i.e., the possibility of tying institutional funding to a curriculum based on the role as delineated and verified, if this curriculum ill fits the institution's mission and interpretation of preparation needs?

3. We need to be aware of the danger of a vocationally oriented Bachelor's-level program.

E. Curriculum Issues

1. Attention must be given in curriculum development to environmental influences on health status as well as individual responsibility for health status.

2. A requirement that the generic, entry-level health educator have both teacher training experience and a community internship may contribute to greater compatibility between these two branches of the profession.

F. Linkages Among Branches of the Profession

1. There needs to be a liaison between departments of education and departments of public health at the State level to coordinate health education programs.

G. Updating the Role

1. Is there an underlying aura of protectionism in the credentialing process?

2. Is there a need to control the number of community health educators who are trained?

I. International Influence

1. What impact will role delineation have on other countries that prepare their health educators in the U.S.?

J. Value of Credentialing

1. Credentialing would give health education identity and status.

K. Teacher Certification and Role Delineation

1. Consideration needs to be given to reconciling the role as delineated with the requirements for State teacher certification. The latter differ among States, but all require specification of content areas. The requirements for teacher certification of some States may be in conflict with the standards being set by role delineation.

Conference Recommendations

Conference Recommendations

Participants in the Birmingham conference worked in 20 groups of 10 to 12 members each, and all contributed to the recommendations that resulted from the group discussion. Each group selected three recommendations to represent the most urgent issues considered. These issues fall into six categories:

1. Continuation of the Role Delineation Project
2. Additions to the document
3. Definition of mission and conceptual framework
4. Credentialing
5. Communications and marketing
6. Professional organization.

Communications and marketing within and outside the profession elicited the greatest number of recommendations from conference participants. Several of these recommendations called for state and/or regional meetings or workshops to acquaint others with the process, to keep the profession informed about the process, and to contribute to the process.

We urge training institutions and professional organizations to take the lead in forming communications networks in their states or regions. The voluntary organization of groups that assume the responsibility of being informed about credentialing activities will provide strong evidence of interest and commitment by the profession and a forum for feedback from practitioners and academicians about project activities.

The following list is a summary, by subject area, of the predominant recommendations made by the 20 conference groups.

I. CONTINUATION OF THE PROJECT

Nine recommendations favored continuation of the project; six of the nine directed the Task Force to provide leadership for the continuing effort. The recommendations as summarized are:

1. That the National Task Force be directed to continue efforts toward credentialing.

    a. Continue sponsorship by the National Center for Health Education to preclude interruption.

    b. Raise funds from the professional constituency to assure support from that constituency in the continuing efforts.

2. That the conference endorse the concept of role delineation for health educators.

3. That the conference endorse the format and process being followed for role delineation.

II. A MISSION STATEMENT AND A PREAMBLE TO THE ROLE DEFINITION

Three of five recommendations specified concepts to be included in a preamble to the role definition. Two recommendations called for two mission statements, one dealing with the profession's contribution to the goals of the nation and the second, with the needs of the profession. The recommendations as summarized are:

1. That the Task Force supervise the development of a position paper detailing how health educators will contribute to meeting the Objectives for the Nation; that the Task Force seek endorsement for this position paper from policy-makers, consumers, and other professions.

2. That the Task Force draw up a mission statement including the concept of health education as a single profession and a plan for credentialing to apply to health educators in all settings.

   a. Continuing education needs should be specified in the plan.

   b. Legal liability resulting from defining our "scope of practice" should be addressed.

3. That the role delineation document include a statement of philosophy and assumptions underlying the role definition and the objectives and of the conceptual framework of the role definition.

III. ROLE DEFINITION AND VERIFICATION

Three of the five recommendations concerned acceptance of the role, as described, for an entry-level health educator; one addressed the need for a definition of "entry level"; and one suggested a way to involve members of the profession in the verification process. The recommendations as summarized are:

1. That the role as delineated be revised to be more realistic for an entry-level health educator. It is too sophisticated for that level.

   a. The role definition should be more general so as to permit flexibility in implementation.

   b. The role should include a "core" common to health educators practicing in all settings.

2. That "entry level" be defined. This definition is critical to acceptance of the role definition.

3. That the verification process begin with institutions, followed by review by (relevant groups) at the state level and then by regional conferences; the regional conferences would give feedback to the National Task Force.

IV. CREDENTIALING ISSUES

There are four categories of recommendation on credentialing issues: acceptance of the concept of standards for the profession; characteristics of the certifying process; structure of a credentialing organization; and the need for more data on the costs of credentialing and health education manpower needs. The recommendations as summarized are:

1. That professional standards be established.

2. That the role delineation document be used as a basis for the development of "standards of practice."

3. That credentialing take the form of voluntary certification administered after a certain amount of experience and represent a person's achievement of an acceptable standard of practice.

   a. The certifying examination should both have a generic base and provide a specialty track.

   b. Certification of community health educators should be separate from that of school health educators and take place one year postgraduation, after full-time employment.

   c. Certification should provide for a "grandfather" clause.

4. That the National Task Force, representing the eight national professional organizations and the representatives to the Coalition of National Health Education Organizations, design

and implement a formal, explicit process during which the professional organizations will consider and present recommendations for a unified vehicle to implement a national credentialing initiative.

5. That more data be gathered about the cost of accreditation/certification in all settings about health education manpower needs.

V. COMMUNICATIONS AND MARKETING WITHIN AND OUTSIDE THE FIELD

Twenty-four recommendations on communications and marketing were made. Eight of these were addressed to the need to inform others about the project and to involve a number of non-health educators in the process; seven recommended additional conferences for institutional faculty and for practitioners; six called for greater involvement of health educators in decision-making related to the project; and three specified certain kinds of communication within the field. The recommendations as summarized are:

1. That the communications network be expanded to include administrators, (employers), certification personnel in State departments of education, and consumers.

   a. As the project develops, engage appropriate experts, e.g., curriculum and evaluation specialists.

   b. Establish increased visibility as a result of the expanded network.

2. That a dialogue be established among academicians, practitioners, and employers to discuss credentialing issues.

3. That publicity be encouraged in business and industrial journals, women's/parents' magazines, etc., regarding the relationship between health promotion and role delineation/health education.

4. That the Conference of Institutions Preparing Health Educators be reconvened in 1-3 years to reaffirm the commitment of the participants and to keep them informed and involved, and that in the meantime, the work of the Birmingham conference be continued on a regional basis, involving younger faculty and more "grass-roots" people.

5. That funds be solicited from health agencies and industry to convene a conference of practitioners.

6. That state associations and organizations sponsor workshops and seminars to inform and stimulate discussion about role delineation and credentialing.

   a. Training institutions and practicing health educators should meet at least regionally to provide a system of checks and balances for the proceedings of this conference and the credentialing process.

7. That leadership on the Task Force be broadened to include professional preparation institutions. Criteria for selecting institutional representation: region, specialty, size of program, representation of private and public schools.

   a. Special efforts should be made to involve programs focusing on ethnic minorities.

8. That leadership on the Task Force be broadened to include more practitioners and non-health educators, and that input from practitioners be sought at each stage of the project.

9. That strategies be developed for marketing the concept of credentialing among training institutions and the leadership of the several health education organizations.

10. That each participant in the Birmingham conference act as a communications link with colleagues and training programs in his/her area.

11. That a voluntary ad hoc professional group be identified, independent of the Task Force, to collect feedback from institutions regarding pilot activities undertaken based on the role delineation document. This group should function immediately and assemble within a year to review and catalog the information--i.e., test instruments, faculty meetings, curricula changes, etc. The ad hoc group should report to the Task Force/Coalition.

VI. ONE PROFESSIONAL ORGANIZATION

Five of the seven recommendations called for a new national professional organization, and two suggested the unification of the "old" organizations into a single association. The recommendations as summarized are:

1. That strong consideration be given to forming a new national professional organization to correct the fragmentation now existing among eight professional organizations.

2. That efforts be pursued toward unification of the several organizations of health educators into a single association.

VII. OTHER

1. That review and consideration be given to what may be the wider social changes (i.e., post-industrial social realities like demographic shifts, role of the family) in influencing the special role of the health educator. (This recommendation will be referred to the working committee for the third phase of the project, i.e., the curriculum development phase.)

2. That the National Center for Health Education begin an immediate job search and referral service. Job opportunities in all settings--community, school, and medical care--would/could be sent to NCHE, and graduates could pay a small service fee for this generic list of available positions at all levels, i.e., B.S., M.S., and Ph.D. (This recommendation has been referred to the National Center for Health Education.)

Presentations

Professional Preparation: An Historical Perspective

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The following statement might have been issued as a charge to this role delineation conference in 1981:

> Recognition of the need for greater clarification of the role of public health educators--and for more adequate preparation of these professional workers--provided incentives for this study.

But, in fact, did this appear in 1981? No, Robert Bowman wrote this in 1958, as a preface to a study that he had conducted during the period of 1953-1956--over 25 years ago. It might seem, therefore, that the field of health education is either endlessly repeating itself, or else standing still. Instead, a study of the history of the last 40 years reveals again the validity of Shakespeare's familiar line, "What's past is prologue." A professional colleague (Sheps, 1975), writing about contemporary trends in public health, states the concept in more forward-looking terms: "In today walks tomorrow."

A study of history is revealing to all of us because, while we have been part of it, affected by events and decisions, and sometimes even ourselves effecting actions and changes, we have seldom paused to study the meaning. As Ann Nolte (1981) has recently reminded us, historical research is not simply the recording of events, but is the giving of meaning, or the bringing of understanding to those events. Facts and information are products of a time period and gain significance as they are examined from the perspective of that time period.

This is a personal perspective that, because of the constriction of time, the purposes of this conference, and my own limitations, must necessarily be a restricted one. Nevertheless, it is my hope that this overview may in some sense help to extend your knowledge of our

professional past--to gain new insight and perhaps gain a greater appreciation of those factors that have shaped our programs, our practices, and indeed, are shaping our deliberations this day and in this conference.

My purpose is similar to that expressed by Theodore H. White, the journalist, as stated in his recent book, In Search of History. Having been a witness to and recorder of so much of our recent history, from 1933 to date, he felt the need to try to organize the meaning of these events. He was angry with himself because for so many years he had neither paused nor dug deeply enough to answer the question, "What is it really all about?" He began to think that it was probably more useful to go back and think over previous events than to go on and add new observations. I too hope that this effort to go back and analyze past events will add enlightenment to our deliberations here.

Health education, as a profession, had its birth during and immediately following World War II. Of course, the concept of health promotion is as old as education itself. Many here are aware of the developments during the first decades of this century, when, according to Sally Lucas Jean, the term "health education" was officially adopted in 1918 to describe a new brand of education. This was championed by a newly established group, The Child Health Organization of America. However, health education did not emerge as a special field of study until the 1940s.

To show more graphically the elements that interacted to form this profession, I have prepared the following table, which might be called the "family tree" of health education. As you can see, it consists of two main trunks--community health education and school health education. Giving form and structure to these two areas (or trunks) are eight major events (conferences or reports), listed sequentially, which culminate in the Role Delineation Project of 1981. I would like to utilize this figure to aid in my analysis of those events from 1943 to date, summarizing their contributions and their effects on each other (vertically) and on the total field of health education (horizontally).

		COMMUNITY HEALTH	SCHOOL HEALTH
	19 80		
		1976 SOPHE Guidelines	1976 ASHA Prof. Pref. Report
			1974 AAHPER H.Ed. Competencies
	19 70		
		1969 APHA - CPE Criteria - Guidelines	1969 AAHPER Certification Standards
		1966 SOPHE Statement SCHS PH Health Education	
		1964 SOPHE Sub Outline	
			1962 AAHPER-NCATE Format
	19 60		
		1957 APHA - CPE	
			1953 USOE Second Conference
	19 50		
			1950 AAHPER Pere Marquette
			1949 USOE First Conference
		1948 APHA - CPE	1948 AAHPER Jackson's Mill
		1943 APHA - CPE	

Figure 1. Professional Preparation Developments in Health Education During the Period 1940-1980, Leading up to the Role Delineation Project

First, however, let me refresh your memory of the Role Delineation Project report and its seven major areas of responsibility. This table should provide a backdrop against which an historical view can be developed.

ROLE DELINEATION PROJECT

(7 Areas of Responsibility)

1. Communicating Health & Health Education Needs, Concerns and Resources
2. Determining Appropriate Focus for Health Education (Needs)
3. Planning Health Education Programs/Responses to Needs
4. Implementing Planned Health Education Programs
5. Evaluating Health Education
6. Coordinating Selected Health Education Activities
7. Acting as Resource for Health & Health Education

Figure 2. 7 Broad Areas of Responsibility Common to the Practice of All Health Educators

The discussion of these past conferences and reports then begins with community or public health education, followed by a review of the school health education-related events. Each area is presented in a chronological sequence. At certain points, the standards recommended seem clearly related to earlier developments, while in others, a parallel or contemporary event seems to have exerted a major influence on the form and the substance of the recommended standards. At times developments in the two fields were closely linked, while in other instances, the two fields moved farther apart both in philosophy and in requirements for professional preparation.

The first report to be discussed is the APHA's 1943 statement on health education prepared by the Committee on Professional Education (CPE). Included among the committee members are some familiar names--Clair Turner, Ira Hiscock, and Henry Vaughan. To my knowledge, this was the first APHA statement on qualifications and standards for health educators.

The committee's report included sections characteristic of all of the CPE statements on educational qualifications, such as functions, educational background, and knowledge and skills needed by health educators. While this was a public health education statement, it is of interest to note that considerable emphasis was given to competencies pertaining to the school health programs including teaching methods and curriculum construction.

Five years later the APHA's CPE published its next report, the first one prepared by a subcommittee entitled Health Education. The format was similar to that of the 1943 report listing key functions and educational background. (Emphasis was given to information dissemination functions.) In addition, seven major areas of competency were identified. At the time of this report, there were estimated to be 460 health educators employed in health agencies, with approximately 300 having completed graduate work in schools of public health. Familiar names on this committee included Turner, Bauer, Derryberry, Grout, Morgan, Southworth, and Winslow.

The next CPE report was issued in 1957. Again Dr. Turner served, this time as chairman of the Subcommittee for Health Education, responsible for the preparation of the report. As before, there were similarities between the standards recommended in this report and the one in 1948. However, for the first time, the function of educational evaluation was included. Qualification as a public health educator implied at least one year of graduate education in public health at an appropriate institution. Undergraduate preparation emphasized (1) social science, (2) biological and health sciences, (3) education and educational psychology. The need for health educators was estimated to be between six and seven times the available supply. Others well known to us serving on this committee included Arnold, Lifson, Larimore, and Yoho.

Because there was a real spurt of activity in the mid-1960s, the following reports are considered as a group: the 1964 SOPHE Subject Matter Outline, the 1965 Schools of Public Health/Health Education

Report, and the 1967 SOPHE Statement on Functions and Minimum Requirements for Community Health Educators. These three reports were integrally related in the development of professional standards during the 1960s. SOPHE was a growing influence in this movement, and the similarity of recommendations and standards reflects the participation of a number of the same people.

A comprehensive core of health education competencies were developed that were translated into the recommended standards. Emphasis was placed on theories of attitude and behavior change, communication, education, learning, and group processes. Other areas stressed included community organization, planning, evaluation, and research. The culmination of this activity was the SOPHE Statement on Minimum Requirements, where for the first time, a differentiation was made between the levels of function and knowledge for professionals prepared at the Bachelor's and Master's levels. Ten major areas of function and areas of knowledge were identified, reflecting the previously mentioned health education core. However, it should be noted that this report also included two subject matter content areas: (1) concepts of physical and mental health and (2) health problems.

Actually, the 1969 APHA-CPE Statement is also directly linked to the preceding developments. This report is significant because it, too, represented the culmination of a great deal of activity in the mid-1960s concerning the preparation of community health educators. At this point, those institutions outside the schools of public health evidenced a strong interest in having their community health education programs accredited. Not only was this accredited status important to the placement of their graduates, but institutions also wanted to be able to share in the public health traineeship funds. The problem was that only the schools of public health were accredited and no way existed, at the time, for other institutions to become accredited!

However, a solution was provided when the Public Health Service, under the leadership of Dan Sullivan, contracted with the National Commission on Accrediting, the predecessor to the Council on

Postsecondary Accreditation (COPA), to develop criteria and guidelines for accreditation. The NCA appointed Ralph Boatman as project director. Dr. Boatman had been directly involved with the recent SOPHE statement and had served as chairman of the Schools of Public Health Report on Health Education. In December, 1967, in Washington, D.C., the NCA hosted a national conference as a first step toward implementation of the report. This Commission report included recommendations summarizing all of these recent health education activities, including the previous four reports and the deliberations of the national conference.

SOPHE STATEMENT 1967

Functions and Requirements of Community Health Educators

Of 10 functions listed, they included:

- Participating in Policy Formulation
- Planning & Directing Educational Programs
- Analyzing Community Health Education Needs
- Implementing & Coordination of Programs
- Serving as a Resource in Health Education
- Conducting Staff Development & Training
- Reporting

Knowledge, Concepts, and Skills:

1. Basic Concepts Physical & Mental Health
2. Health Problems & Services
3. Determinants of Behavior
4. Basic Public Health Concepts & Methods
5. Health Education Methods
6. Administration, Supervision & Consultation
7. Program Planning, Implementation & Evaluation

Figure 3. Functions Identified and Areas of Preparation in the 1967 SOPHE Statement that are Reflected in Currently Recommended Standards

The 1969 APHA-CPE criteria and guidelines developed for the preparation of community health educators grew directly from the report submitted to the Public Health Service in 1968. Its criteria not only affected those institutions seeking accreditation for the first time, but also established standards for preparation of all community health education specialists. Marjorie Young chaired the 1969 APHA-CPE Task Force on Health Education. It is noteworthy that she had also served as a member of the steering committee working with Ralph Boatman on the NCA reports.

The 1976 SOPHE Guidelines provides an introductory statement that effectively sets forth the purposes and the methodology of the health education specialist.

> Health education is concerned with the health-related behaviors of people. Therefore, it must take into account the forces that affect those behaviors, and the role of human behavior in the promotion of health and the prevention of disease. As a profession, it uses educational processes to effect change or to reinforce health practices of individuals, families, groups, organizations, communities and larger social systems. Its intent is the generation of health knowledge, the exploration of options for behavior and change and their consequences, and the choices of the action courses open and acceptable to those affected.

The question of standards, certification, and licensure was the central issue, and the decision to use the term "guidelines" apparently was made in order to avoid forcing that issue. The SOPHE report again differentiated between the functions of the baccalaureate and the Master's level professionals. The term "community health educator" was dropped in favor of "health education specialist." Because of the increasing variety of occupational opportunities available, the term "community" was insufficiently inclusive to describe these new roles of the health educator.

Let us now move to the other side of our genealogy and highlight some of the school health developments, starting with the 1948 Jackson's

Mill Conference (AAHPER). Contemporary programs of professional preparation for school health educators originated, to a great extent, with the recommendations arising from this conference. According to Means (1975), this was the first national conference on undergraduate professional preparation for health education to be held in the United States. Here one of the first systematic attempts was made to crystallize the thinking of professional leaders in the formulation of standards and recommendations for the preparation of specialists in health education. Moreover, the conference attempted to determine those elements essential to the preparation of both the classroom teacher and the community health education specialist.

SOPHE GUIDELINES FUNCTIONS 1976

Bachelor's - Master's Level Distinctions

6 Areas

1. Foundations for Health Education
   - Basic Elements Health & Well-Being
   - Contemporary Health Problems
   - Health Aspect of Physical Environment
   - Health Aspect of Psychosocial Environment

(Community - Schools - Health Care - Occupational & Industrial Settings)

2. Administration of Health Education
3. Program Development & Management
4. Research & Evaluation
5. Professional Ethics
6. Special Applications of Health Education

Figure 4. SOPHE 1976 Guidelines Reiterating Earlier Recommendations. New Areas Recognized: Research and Evaluation; Professional Ethics and Special Applications (i.e., School, Community, Patient Education, etc.)

Immediately thereafter, the U.S. Office of Education called its first national meeting in 1949. This conference was unique in that it was devoted exclusively to the problems of health education. One of the highlights of this conference was the recommendation calling for "a common curriculum for the preparation of the public health educator and the school health educator at the undergraduate level." Representatives of both the public health and school health fields supported this proposal. It was also agreed that specialization in these fields should take place during the fifth year of study. Then following in quick succession came the 1950 Pere Marquette Park Conference (AAHPER), which was concerned with graduate study. Its focus was the evaluation of graduate programs and the procedures for accreditation. Much of the current demand for an effectively functioning accreditation procedure stems from this conference.

The Second National Conference on Professional Preparation of Students Majoring in Health Education, sponsored by the U.S. Office of Education, was held in Washington, D.C., in January, 1953. Its areas of concern included both undergraduate and graduate study in health education and matters pertaining to the specialized curriculum of health education. H. F. Kilander was a prime mover in both of the USOE conferences.

Probably the most influential statement coming out of the second national conference was the list of specific courses recommended in a "desirable undergraduate curriculum for the major in health education." The courses were organized under two broad headings: (1) health sciences--personal health, community health, sanitation, nutrition, mental health, family living, home nursing, first aid, safety education, driver education; and (2) professional subject areas--methods and materials, school health administration, school health environment, school health evaluation, and student teaching and field experience. The importance of accreditation was again stressed in pointing out that "the lack of accreditation for institutions preparing school health educators seriously impedes the recruitment, preparation, and placement of qualified personnel." (Creswell, 1964)

SECOND NATIONAL CONFERENCE USOE 1953
UNDERGRADUATE MAJOR HEALTH EDUCATION

Health Science Areas:	Professional Subject Areas:
Personal Health	Methods & Materials
Community Health	School Health Services
Sanitation	Healthful School Environment
Nutrition	School Health Administration
Mental Health	School Health Evaluation
Family Living	Student Teaching & Field Experience
Home Nursing	
First Aid	
Safety Education	
Driver Education, Other	

Figure 5. Areas of Professional Preparation Recommended in this Report, Based on the 1948 Jackson's Mill Conference and the 1948 APHA-CPE Report

The two U.S. Office of Education-sponsored conferences were planned specifically to follow up on the thinking and the planning that took place at the Jackson's Mill and Pere Marquette meetings. The close professional interrelationship that existed in the earlier conferences is clearly evident from the proceedings of this second conference, which reported that the experiences offered by the colleges and universities preparing health educators should include all the competencies recommended by the Jackson's Mill conference and, in addition, should include all of the professional competencies outined in the APHA report on qualifications of community health educators. (Kilander, 1961)

As background to the 1962 National Conference, it should be pointed out that AAHPER had recognized the National Council for Accreditation of Teacher Education (NCATE) in 1960 as its official accrediting agency. This action, coupled with the need to reexamine programs in light of NCATE's standards, led to the development of the National Conference on Professional Preparation, held in January, 1962.

How did the 1962 program of specialization in health education differ from programs recommended by earlier conferences?

1. While the recommendations concerning the basic sciences are quite similar, the delegates to the 1953 conference called for more applied sciences, such as human biology, rather than zoology.

2. The 1962 conference delegates placed greater emphasis on the social sciences, especially those now known as the behavioral sciences.

3. The 1962 conference delegates specified fewer courses but recommended broader course areas. For example, instead of calling for specific courses such as health services and school health environment, the recommendation was for courses in school/community health programs.

In 1969, AAHPER held another conference. This time the focus had shifted from accreditation to the certification of health education teachers for secondary schools. The major concern at this time was the shortage of well-trained teaching personnel. Standards for such teacher certification were recommended, and included (1) general education requirements, (2) biological sciences, (3) physical sciences, (4) the behavioral sciences, and (5) minimum requirements for professional preparation in health education.

A major issue at the time was the need to separate the certification for health education from that for physical education.

The 1974 National Conference on School Health Education resulted from a decision to revise the preparation guidelines developed in 1962. It was unique, first, in regard to the development of extensive pre-conference working papers and, second, by opening the ensuing conference to all members of the profession in order to achieve a democratic, "grass-roots" approach. The basic program design recommended for the curriculum resembled earlier conference decisions, including the following broad categories: (a) general studies, and (b) professional studies.

This conference emphasized accountability, in which recommended standards were written in the form of competency-based and performance-based objectives, representing the extreme position of all preparation conferences in terms of the degree to which standards were written in the form of specific objectives and behaviors.

The final conference to be discussed is the 1976 ASHA Committee on Professional Preparation and College Health Education Conference, which was held at Towson State University. Participants took note of the preceding reports and decided to review the existing documents, select the best parts, and make suggestions for further improvement. The outcome of this conference was a recommended "standarized model" program for professional preparation that was widely disseminated to professionals in the field for review and criticism. The utility of this model program seems to have been demonstrated by its fairly widespread use.

Up to this point I have tried to stick pretty close to the script--that is, a reasonably straightforward accounting of what these conferences and reports were about. Now, in addition to a summation, I should like to add a personal observation or two.

I believe the following list summarizes the major points of agreement relating to these school health education professional preparation conferences.

COMMON AREAS OF PROFESSORIAL PREPARATION
IN SCHOOL HEALTH EDUCATION

1. Foundation Sciences of Physical and Biological Sciences
2. Social and Behavioral Sciences
3. A Common Core of Health Content Courses, Professional Health Education Courses, and
4. The Skills of Professional Practice

Figure 6. Areas Generally Reflecting Recommendations of the Professional Preparation Conferences Held During the 1960s and the 1970s

Figure 7 illustrates the content sections of two of our most recent school health education conferences: the AAHPER 1974 conference, and the Towson State-ASHA 1976 conference. I would like to contrast Figure 7 with Figure 2, depicting the Role Delineation Report and its seven areas of responsibility. To my way of thinking, the issue is one of balance between what I have characterized as a content orientation and a process orientation (see Figure 8).

Conclusion

Upon completing a review of this nature, with its heavy emphasis on fact, one important point may have been obscured. These conferences and reports resulted from the efforts of people. As Theodore White observed, individuals make history. He realized that identities in politics are connected to ideas and that at the core of every great political identity lies an idea that the leader has absorbed, changed, and imposed on others.

So it is in fields other than politics. The profession of health education has been and continues to be influenced by men and women whose identities are connected to ideas. These ideas have created health education and have influenced us in the making of our contributions. We feel a sense of obligation to the leaders and the workers in this field who have gone before us. Many of them because of death, retirement, ill health, or change of responsibility no longer play active leadership roles. I speak of people like Clair Turner, Sally Lucas Jean, Charlie Wilson, Bernice Moss, Mayhew Derryberry, Mabel Rugen, Carl Anderson, Ruth Grout, Beryl Roberts, Del Oberteuffer, Mike Hoyman, Keogh Rasch, Marjorie Young, Kellie Kilander, Tex Byrd, Fred Hein, Dorothy Nyswander, Wally Wesley, Elsa Schneider, Si McNeeley, Ruth Abernathy, Ned Johns, Bob Bowman, Ralph Boatman, Wes Cushman, Warren Southworth, Bob Yoho, and many others. The mentioning of their names causes us to realize anew the magnitude of the legacy and the responsiblity they have given us.

The future is now--the opportunity is here and the challenge is before us--good luck!

CONTENT FOR THE HEALTH TEACHING SPECIALTY

AAHPER 1974	ASHA 1976
1. Environmental Health	1. Personal Health
2. Mental Health	2. Community Health
3. Alcohol, Tobacco & Drugs	3. Alcohol, Tobacco, & Drugs
4. Nutrition	4. Human Sexuality
5. Communicable & Noncommunicable Diseases	5. Mental/Emotional Health
6. Human Sexuality	6. Ecology/Environment
7. Dental Health	7. Nutrition
8. Physical Fitness	8. Aging
9. Consumer Health	9. Death
10. Community Health	10. First Aid/Emergency Care
11. Accident Prevention	11. Safety
	12. Communicable & Noncommunicable Diseases
	13. Exercise & Fitness
	14. Consumer Health
	15. Dental Health
	16. Health Careers

Figure 7. Health Content Emphasis Characteristic of Professional Preparation for School Health Educators

ISSUE OF BALANCE

CONTENT (Orientation)	PROCESS (Orientation)
1. Environmental Health	1. Epidemiology
2. Mental Health	2. Biostatistics
3. Nutrition	3. Health Services Administration
4. Sexuality	4. Environmental Health (Health Education Perspective)
5. Drugs-Tobacco-Alcohol	5. Communication Theory
6. Consumer Health	6. Communication Techniques (Education Methods)
7. Dental Health	7. Community Organization
8. Concepts of Disease	8. Group Process
9. Physical Fitness	9. Behavior Change Prog.
10. Community Health Problems	10. Learning Theory
11. Accident Prevention	11. Needs Assessment

Figure 8. Content Orientation Characteristic of Professional Preparation in School Health Education and the Process Orientation Characteristic of Preparation in Community Health Education

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The Objectives for the Nation in Disease Prevention and Health Promotion: A Challenge to Health Education Training

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Director, Office of Health Information, Health Promotion, and Physical Fitness and Sports Medicine
U.S. Department of Health and Human Services

Distinguished deans, fellow professors, and health educators concerned with professional standards: After Dr. Creswell's tour de force of the history of efforts by committees and conferences in the past to address the questions of professional preparation and standards in health education, my purpose at this point is to convince you not to despair at yet another conference; that, in fact, this is a particularly opportune time to have convened once again to address these questions. Dr. Creswell summarized his conclusions with a reference to Theodore White, but what he did, in fact, was to disprove White's thesis that individuals make history. It seems from his report that committees make history. You would be correct if you were to point out that there are few statues of committees in our public parks. But we must nevertheless recognize that committees and conferences are essential to progress and consensus on matters that affect people whose work reflects various perspectives.

The purposes of this conference have been outlined for you from various perspectives. My own concerns as a cosponsor but also as a health educator are to assure that our effort to delineate the roles of health educators for the future and the tasks of training for health education in the future are properly cast in the context of the national objectives for disease prevention and health promotion. These objectives are themselves the product of considerable consensus-building among various professions and interest groups. I am going to focus in these remarks more on those objectives than on Healthy People, the Surgeon General's Report on Health Promotion and Disease Prevention, because for most of you that is by now history. You have seen the

report; most of you have had time not only to read it and to study it but also to share it with your students and to teach some of your courses around it. The copies of Objectives for the Nation that were distributed to you tonight are so hot off the press that the red ink may smear on your hands. Those objectives follow on the Surgeon General's Report; they are the next step in the process of national consensus and policy development in health promotion and disease prevention.

The objectives, as you will note from the material in your packet, are the product of a thorough and systematic process of consensus development across the nation, across professional disciplines, across lay interest groups, and across public and private sector institutions and organizations. All of this consensus has been tempered in the final product by economic realities, political projections, and international comparisons of what should be possible over the coming decade. We have never had, in my view, in concert with our colleagues in other professions, a more specific, concrete, quantified, and widely accepted set of destinations and guideposts for a full decade ahead in disease prevention and health promotion. We have wandered in a wilderness of confusing and sometimes conflicting goals, if we had any at all. Now we have a set of national objectives on who should be expected to achieve how much of what benefits by when. These are not rigid standards; these are not Federal guidelines--they are national guideposts to be adapted to local situations and special population needs. They are not a complete road map--only a set of destinations and markers.

How the Objectives Can Help Delineate Roles

We must decide here at this meeting, I believe, the various paths health education should follow and the vehicles it can offer to empower the public to achieve these ends. Look at the objectives in this document in two ways--first, as a statement of priorities for national attention in order to yield the greatest benefits to the health of the American people. The 15 chapters represent 15 priorities for action to improve the health of the nation (see Table 1). As a set of priorities, they can guide our deliberations here in assuring that we are training

Table 1. Priority Actions for Health from Objectives for the Nation in Disease Prevention and Health Promotion

Preventive Health Services

- High Blood Pressure Control
- Family Planning
- Pregnancy and Infant Health
- Immunization
- Sexually Transmissible Diseases

Health Protection

- Toxic Agent Control
- Occupational Safety and Health
- Accident Prevention and Injury Control
- Fluoridation and Dental Health
- Infectious Agent Control

Health Promotion

- Smoking Reduction
- Reducing Misuse of Alcohol and Drugs
- Improved Nutrition
- Exercise and Fitness
- Control of Stress and Violent Behavior

health educators for roles that are relevant to the priorities for the nation's health. Second, look at this document as a resource document on suggested prevention and health promotion methods against which the roles, functions, and activities of health educators may be held accountable.

How the Objectives Can Strengthen Health Education Practice

The cycle of poverty of health education programs has been characterized in the past by inadequate support for health education. As a result, goals and methods have been diffuse and of questionable quality. The result has been only modest and scattered impact, and the result of this dilution is that any social benefits have been either missed or undetectable. It has been impossible to make a case persuasively with policy-makers for additional support. And so inadequate

support has perpetuated the cycle of poverty for health education. We have begun to break into that cycle at several levels, particularly with evaluation, as seen in Figure 1.

When a profession or any other enterprise cannot depend on a single source of revenue, it must diversify its portfolio. Health education has had brief periods of greater support from one categorical health concern or another, such as immunization programs in the early sixties, family planning and drug abuse in the late sixties, hypertension in the early seventies, alcohol and smoking in the late seventies. But with these constantly shifting priorities, long-term objectives could not be pursued systematically and diligently. Professional training programs could not keep up with the changing job market and expectations for proficiency in the field. Employers could not count on health educators trained yesterday to understand today's priorities.

THE PROFESSION'S CYCLE OF POVERTY

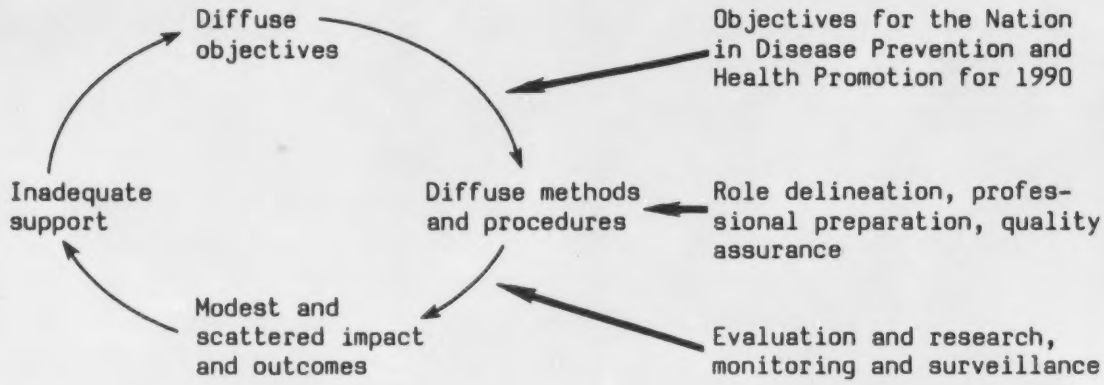
Diffuse objectives
Objectives for the Nation in Disease Prevention and Health Promotion for 1990
Inadequate support
Diffuse methods and procedures
Role delineation, professional preparation, quality assurance
Modest and scattered impact and outcomes
Evaluation and research, monitoring and surveillance

Figure 1. The Cycle of Poverty for Health Education. Here the cycle is redefined to emphasize the points of intervention addressed by current federal policy (adapted from L. W. Green, M. W. Kreuter, S. G. Deeds, and K. B. Partridge, Health Education Planning: A Diagnostic Approach, Palo Alto, California, Mayfield Publishing Company, 1980).

With the 10-year time frame of Objectives for the Nation, we have an opportunity at the beginning of 1981 to plan and focus our professional preparation of health educators on 1990 targets that are diverse enough to assure multiple sources of support, yet specific and distant enough to assure concentration and continuity of our efforts in training and program development.

We have begun to accumulate a literature that assures us that there is an immediate impact of health education that is detectable and significant. We have begun to accumulate some even longer-term evaluations of outcomes, hard outcomes in terms of health benefits. Cost/benefit evaluations have yielded indications that the benefits in health and economic terms outweigh the costs of health education programs. But we continue to slip and slide in this construction of health education's case for more resources because we have failed to articulate our provisions for quality assurance, peer review, and the clarification of the goals, objectives, and methods of practice in health education. That is what we are here to address at this conference, and this is where the Objectives for the Nation in Disease Prevention and Health Promotion can be helpful.

How the Objectives Can Strengthen Public Support for Health Education

There are some other cycles that need to be understood in examining the history and the current status of health education. The decision cycles in health policy and the allocation of resources for health programs can be viewed as overlapping professional decisions and public decisions, as seen in Figure 2. Theory must be translated into policy, and it must be understood by the public that will support policy. Policy is best expressed in the form of objectives. That understanding in the public will result in certain demands and expectations that will influence policy as well as influence practice to the extent that practitioners have direct contact with the public. Practice results in evaluations that build theory, and theory, in turn, can help to build policy and public understanding at another plateau. Where do you fit in that? Where does training fit?

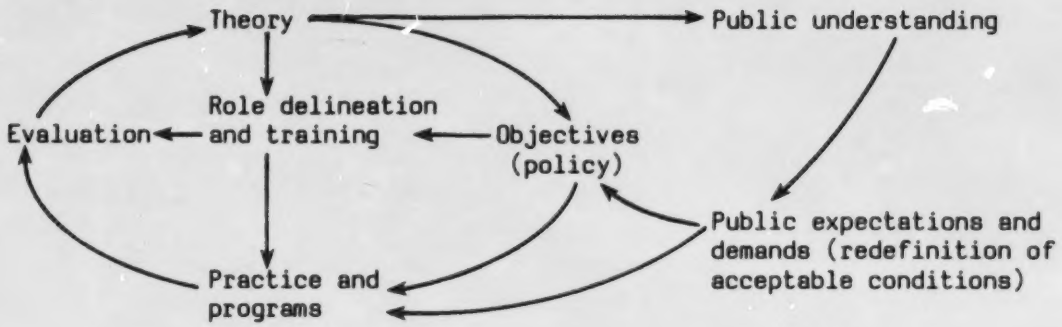

Figure 2. The Overlapping Cycles of Professional Decisions (on the left) and Public Decisions (on the right) (Adapted from L. W. Green, "National Policy in the Promotion of Health," International Journal of Health Education 22:161-168, July-September 1979; and "The Changing State of Science in Health Education," Focal Points, April 1980, pp. 19-23.)

How the Objectives Can Strengthen Professional Training in Health Education

Training, it seems to me, is right in the middle of the cycle on the left because theory influences training, policy influences training, training influences practice, and evaluation influences training.

In addressing training at this conference, we have to be concerned simultaneously with these interacting influences of theory and with objective statements of policy, practice, and evaluation, and all the while understand that public understanding of these things will be necessary to support policy.

One outcome we do not want from role delineation is to mechanize health education practice so much that it will be viewed by the public as a perfunctory, technological process. That is not what objectives are all about. The other thing we do not want to do is to make the goals of health education so monolithic or so unilateral or unidimensional as to make them ill-fitted for large segments of a pluralistic society, imposing majority values on minority populations. We have strived in our development of national implementation plans to consult and incorporate the special concerns of Blacks, Hispanics, Asian

Americans, American Indians, and the elderly. The concept of lifestyle, for example, could be intimidating or oppressive to some people if it were conceived to be a uniform that everyone must wear equally. But we do need to clarify our objectves and roles if we are to be effective and responsible, not to say efficient, in our preparation of professionals for practice in health education. We must understand that our outcomes depend on the quality of our professional practice, which we will determine through professional training and other quality assurance mechanisms. Let me define these terms more sharply for purposes of discussion over the next couple of days.

How the Objectives Can Help in Quality Assurance

Quality I define as the appropriateness of a specific set of professional activities, in our case, educational or administrative activities, as performed in relation to the objectives they were intended to serve. That is what evaluation and theory are particularly about. From evaluation and theory we construct our notions of what are appropriate, specific sets of professional activities in relation to specific objectives.

Quality assurance we can define as accountability for professional activities to someone who needs to know they are appropriately performed. That is where we must strengthen role delineation and the reporting mechanisms that may come out of that, whether it be in the form of credentialing or some other form of reporting or accountability to the public. Quality control is the mechanism or procedure for obtaining quality assurance. This is where monitoring and surveillance, including credentialing, particularly come to rest. Credentialing can be regarded as a quality control mechanism. The specific methods of accountability toward which we might be working for quality control, beyond basic training, might include accreditation, certification, licensure, continuing education, consumer policy committees, and peer review.

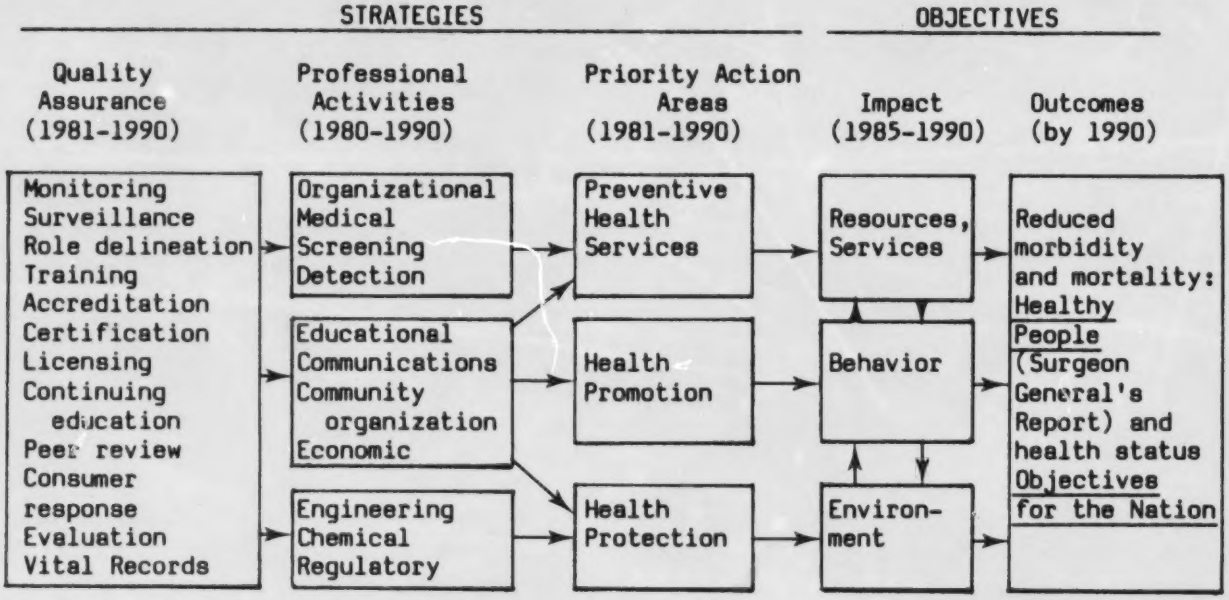

Figure 3. Relationships Among Components of the Federal Initiatives in Disease Prevention and Health Promotion (Adapted from L. W. Green, "Healthy People: The Surgeon General's Report and the Prospects," Chapter 3, in W. J. McNerney, Ed., Working for a Healthier America, Cambridge, Massachusetts, Ballinger Publishing Company, 1980, pp. 95-110; and L. W. Green, R. W. Wilson, and K. G. Bauer, "Objectives for the Nation in Health Promotion and Disease Prevention and Requirements to Measure Our Progress," Proceedings of the 18th National Meeting of the Public Health Conference on Records and Statistics: New Challenges for Vital and Health Records, Washington, D.C., Office of Health Research, Statistics and Technology, NCHS, DHHS Publication No. (PHS)81-1214, December 1980, pp. 229-234.)

How do the three tasks for this conference hang together? There is, first, the task of examining the roles delineated in the July 1980 Focal Points document from the Role Delineation Project. There is the second task of looking for the implications of that document and our recommendations for revision of it, for training, for training institutions, and for students in professional training. Then there is the third task of assuring that all of this relates with some degree of relevance to the Objectives for the Nation as derived from the consensus development process that we have been through in the Federal Government on a national scale with public and private sector involvement.

I would like to take issue with only one definition in the July 1980 Focal Points document that you will be working from, and that is the definition of health education. I do not mean to impose my preference for a definition but just to document my disagreement with the working definition proposed by the Role Delineation Project, which I find unworkable: The definition of health education that I find more workable in relation to quality assurance and role delineation is one that emphasizes the combination of learning experiences designed to support voluntary behavior conducive to health. John Dewey once said that since a democratic society repudiates the principle of external authority, it must find a substitute in voluntary disposition and interest. These can be created only by education. It is in that context that we have the opportunity today to show what education has to offer because the health problems that we are addressing today, as outlined in Objectives for the Nation and the Surgeon General's report, are ones for which more coercive means of behavioral control are not going to be acceptable in this society as were the infectious disease control measures of the past. How does this relate to the broader goals and objectives of disease prevention and health promotion, the third task for the conference?

Structure of the Objectives for the Nation

Health education is one of the many enterprises or technologies contributing to the Objectives for the Nation. Others include political, social, economic, organizational, engineering, and medical interventions. These strategies, including health education as one of the leading methods, are to accomplish objectives in each of the 15 areas of priority broadly grouped under three categories called health promotion, preventive health services, and health protection. The accomplishment of those Objectives for the Nation should achieve the broad goals for the five age groups as outlined in Healthy People, the Surgeon General's Report on Health Promotion and Disease Prevention. The processes that we have been through in arriving at these objectives have included Federal task forces chaired by Dr. Michael McGinnis, Deputy Assistant Secretary for Health, to get the act organized, but

then an increasingly broad-based national consensus development process that led to the publication of Healthy People, and since then the development of the objectives. The objectives grew out of a process of consulting with large numbers of experts and then distributing drafts of the objectives to a wide audience of potentially concerned lay and professional interest groups, organizations, and institutions, public and private. The comments of the three thousand or so individuals and organizations that received the draft objectives were sifted and reconciled and finally put together in the document that you have. Implementation plans are now being developed in each of those 15 areas.

The questions that the implementation plans raise are such questions as Who shall be expected to perform some of the activities necessary to accomplish these objectives? That is why this is not only an important time for us to be addressing this issue, but an opportune time.

Table 1 and Figure 3, as you will note, organize the objectives into three broad groups, preventive health services (related to medical interventions or settings), health protection (related to environmental interventions), and health promotion (related to behavior). The preventive health services, however, contain some objectives that can be accomplished best outside the medical care settings, and health promotion requires organizational and environmental supports for behavior within medical care settings, so that it is not a clear-cut delineation. The objectives relating to sexually transmitted diseases can illustrate the structure, starting with objectives for improved health status. "By 1990, reported gonorrhea incidence should have been reduced to a rate of 280 cases per 100,000 population. In 1979, the reported case rate was 457 per 100,000 population." Each objective is stated in terms of the time by which it should be accomplished, the population who should benefit, and when they should experience that benefit. "By 1990, reported incidence of primary and secondary syphilis should be reduced to a rate of 7 cases per 100,000 population per year, with a reduction in congenital syphilis to 1.5 cases per 100,000 children under one year of

age. (In 1979, the reported incidence of primary and secondary syphilis was 11 cases per 100,000 population, while reported congenital syphilis was 3.7 cases per 100,000 children under one year of age.)"

The behavioral and educational objectives appear not in the category that states the health status objective, as above, but in the next two categories in the hierarchy of objectives that go from improved health status to reduction of risk factors to public and professional awareness. In the risk factor category, there are usually some behaviors that need to change. From there, the hierarchy progresses to objectives related to public and professional awareness, a broad heading that includes a wide range of cognitive phenomena. In that category I think you will find most of the short-run, immediate objectives that health education ought to be accomplishing. In fact, the nation is depending on health education for the accomplishment of these educational objectives, and without their accomplishment we are unlikely to achieve the risk factor reduction objectives and ultimately the health status objectives. Following the public and professional awareness objectives in each chapter are health services and protection activity objectives, and finally a category of objectives for measurement and evaluation, emphasizing increased surveillance and record-keeping systems to enable us to track our progress toward the objectives over the decade.

In addition to the objectives, there is a background prior to each set of the objectives that includes the nature and the extent of the problem, and suggested prevention and promotion measures, prominent among which are information and education measures. For each of the 15 areas, including those in the environmental health protection category, many of the prevention and promotion measures suggested are in fact educational. For every category there are some educational measures suggested in addition to the objectives for behavioral risk factors and public awareness.

Not all of the health status objectives are stated in rates per 100,000 population, but some of them are stated in terms of numbers, as in the case of the incidence of immunizable diseases. For those we are looking toward the near eradication of some of the infectious and communicable diseases. In fact, there is talk today of the possibility of eradicating measles. But I point to this particular set of objectives because it illustrates how some of the objectives associated with preventive health services are going to depend upon schools for their accomplishment. Indeed, we have estimated that approximately one fourth of all the objectives will depend on the cooperation of the education establishment for their accomplishment. If we cannot come to some agreement here among ourselves as health educators, it is unlikely that the rest of the education and health establishment will come to terms on the cooperation of schools and health agencies.

The objectives in the broad category of health protection include those that have to do with the environment, including the workplace environment: toxic agent control, fluoridation of community water supplies, infectious agent control, accidental injury control, and occupational safety and health. These again include a large number of objectives and measures that are educational in character. Half of those in occupational safety and health relate to worker education and the rest to management and professional education.

Then, the last broad category is health promotion, where the objectives fall into five categories--in order of priority, the reduction of smoking, alcohol and drug misuse, nutrition, physical fitness, and stress and violence control. They are in that order of priority because of the state of the art and because of the epidemiological knowledge that those are the things that could make the biggest difference in terms of morbidity and mortality in this country. It is recognized that interventions tend to follow this order of success. But it is acknowledged, on the other hand, that if we could solve the stress problem, we might solve all the others simultaneously.

In every case the Federal questions in developing national policy, as I believe will be the case in developing State and local policy, come down to questions of how we divide the labor among organizations and the health professions to accomplish these objectives. That is the task of role delineation and professional training to be addressed here as we sort out the functions of school, community, and patient education.

Credentialing for the 1980s

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I want to thank you for the opportunity to address you this morning on a topic of paramount importance to each of you and your organizations. The credentialing area in general is one that is frequently misunderstood and one that is often misrepresented.

I've been speaking out on the credentialing issue across the country for a number of years.(13) (14) (15) (16) (17) In many organizations and states, my views are well known. I'm fortunate in that I'm allowed to speak my piece and make my case without necessarily reflecting the views of my employer, New York State. If I am ridden out of town on a rail, I'm on my own. On the other hand, if you like what you hear, they take all the credit for my upbringing. It's a kind of reversal of the old story about the company of college grads during World War II who wouldn't sign up for GI insurance, despite the fact that the battalion had a record of more than 75 percent compliance. After lengthy appeals from the major, the lieutenant, an Ivy League graduate, asked to take a turn. His appeal was based on the need for giving it the old college try--let's give all for the red, white and blue. The compliance rate went up to 20 percent. Finally, an older, wiser noncom came forward and asked to be given a chance to tell it like it is. "Look here, you guys," he began, "let's forget all this junk you've heard and follow me to the bottom line. If you sign up and go and get killed, the government is gonna send your family 10,000 dollars each. If you don't sign and get killed, the brass send your family nothing. Now, if you was the government, who would you send overseas to get killed?"

This morning, I hope to cut through the esoteric jargon and get us to that bottom line, even if it means getting killed along the way.

The whole area of credentialing is no longer in the land of the mystical. Regulatory programs are very much in the public eye, particularly those that are regulated by law.(11) As a group, professional practitioners are no longer a venerated segment of the population.(6) On the contrary, they are more and more frequently being criticized, even attacked, by an increasingly litigious public. Licensing laws are being subjected to sunset legislation in several dozen states, with some licensing boards legislated into oblivion, in some cases for good reason.(9) The message should be loud and clear--a regulatory program, if it is to survive in the years ahead, must be meaningful, necessary, and certainly in the public interest.

Basically, there are two kinds of regulatory program, statutory and voluntary. Let me address statutory credentialing first.

A statutory regulatory program is one that usually comes about as a result of legislative action of some sort, most commonly, an act of a State governing body. In the past, groups comprising mostly members of professional societies lobbied for a regulatory act, which eventually found itself on the books as a State law. However, one of our better-known State legislators told me a few years ago that if most proposals on record today were to be reintroduced now, few, if any, would succeed.

The fundamental reason for regulating an occupation is to provide the public with some degree of protection. If the primary beneficiary of any credentialing scheme is the practitioner, the proposal should never be enacted.(20) Now we all admit that the best proposal designed with the public good in mind will result in potential benefit to practitioners as well, but such benefits must be outweighed by far by the public and societal needs being met.

Regrettably, terms used to describe regulatory programs are neither consistent nor universal. In some instances, the same ones are used, but in different ways, in statutory and voluntary programs. Sometimes our efforts to communicate in the most simple manner lead us astray.

I'm reminded of a recent event during the just-completed census when an investigator sought out an area's old-time resident, having been told that this aged man would have a load of important demographic data at his fingertips. The census-taker asked the man whether he could shed some light on the death rate in his neighborhood. After considerable silent thought, the man said he'd finally figured it out. "I've concluded," he said, "that the death rate in this neighborhood is one per person."

In a statutory credentialing program, the most restrictive, most costly program is one of licensure. Simply stated, in this scheme, a license issued restricts a practice. Frequently, licensure limits the use of certain titles as well, but the primary emphasis in licensure is on restricting practice.(5) For example, a license to practice medicine limits the broad practice of medicine, whatever that is by definition in the law, to a license holder. In most cases, the license also denies those not licensed the use of certain titles. In New York State, for example, only a licensee can claim to be a "physician." Now many non-licensed medical school graduates use the title "doctor," but only a licensee may, under the title "physician," practice medicine.

Another form of statutory regulation is certification, a term also used frequently in voluntary credentialing programs. Again, simply stated, a statutory certification act does not restrict any particular practice, but only the use of a title.(5) There are a variety of examples available. In many states, psychology is a certificated profession, as are professional engineering and, in some cases, social work. While many persons may perform tasks usually identified with psychologists, social workers, or engineers, only persons holding such certificates may use those restricted titles. Now, as if this isn't complicated enough, let me muddy the waters a bit more by referring to some states in which everything issued is called a license, though some licenses restrict practice, whereas others restrict only a title. Despite these few anomalies, however, these dichotomous distinctions hold in most cases. Other forms of statutory regulation of an

occupation exist, the most basic being registration,(5) in which anyone that meets an established set of qualifications may choose to register with the regulatory agency and have his or her name placed on a list of registrants. This process limits neither a practice nor a title, but only provides a list of registrants from among whom the public may choose, should it wish.

This right of the public to choose a practitioner is one now being debated at the highest government levels. A basic question is whether or not government has either the right or the responsibility to restrict practice.(22)

No regulatory program should exist at a level beyond that absolutely necessary to protect the health, safety and welfare of the public. If simple registration will suffice, there can be no justification for licensure or certification. To propose any program, there should be sufficient evidence of need, and detailed data as to why a lesser form is unworkable. Of course, it is axiomatic that even before such data are collected, there must be evidence that absence of regulation of some sort results in recognizable damage to an unsuspecting public.

A voluntary credentialing program is almost universally the function of a state, regional, or national professional association. However, there is no deterrent to a government agency adopting the standards of such a system and incorporating it within its own governance of the state's work force. However, a State may not abrogate its responsibilities for setting minimum standards for entry into a statutory regulatory program, nor may a professional association abrogate that responsibility to itself. However, in a voluntary program, an interdependent relationship between the State and a professional association can and hopefully will develop, wherein standards can be agreed upon mutually, and the purposes of each participant can be accomplished.

Within a voluntary credentialing program, certification can take on meanings quite different from those of the statutory system.(2) A certificate can be more than a single-purpose document. It may signify the meeting of standards for the competent practice of the profession generically, or it may be used to denote specialty qualifications of one sort or another, even excellence in general or specialty practice. Such is certainly not the case with statutory certification in a program. To explain that, let me digress a bit.

In a State-mandated credentialing program, the entry-level license or certificate, or whatever is granted, usually carries with it only a very loose and almost meaningless quality component. It is no assurance of quality or competence.(14) I've heard (and even at times in the past, used) the term "minimum competence." Now, without intending to get into a semantic argument, I find the words "minimum" and "competence" just don't belong together. They remind me of trying to join "slightly" and "pregnant" into something meaningful. George Carlin, in his several lectures on words we use, or shouldn't use, together, has a variety of other examples, many of which I think I won't mention here. It reminds me of the philanderer who justifies his actions by claiming to wear his wedding band only "loosely," failing to accept that a wedding band, no matter how loosely worn, always cuts off circulation.

"Minimum" and "competence" just don't go together. The initial license is a signal to the consumer only that when it was issued, the regulatory agency found the practitioner to be one who could practice <u>safely</u>, not likely to be of potential harm to a client. Now certainly that has a loose quality or competence component, but a guarantee of either quality or competence it is not. Furthermore, once a license has been issued, it cannot be assumed that the level of safety judged at the time of issuance has continued. We are, or at least should be, far beyond that day when we believed that a licensed or credentialed person maintained or improved skills just through daily practice. At one point in time, we were deluded into believing that licensure equaled competence, and that once licensed meant forever competent. That myth must

be dispelled once and for all. Nonetheless, in a statutory program, the determination of what shall be required for entry-level credentialing is a function of the State, usually carried out by the State board for the profession. On the other hand, in a program that is voluntary in nature, the professional society may establish, and usually does set standards for, the issuance of the basic credential. It has been my experience that many voluntary credentialing programs set standards for the entry-level certificate at a level higher than that mandated in a State-regulated system, though such need not necessarily be the case.

The last decade in particular has been notable for attacks on mandatory (that is, State-regulated) programs, coming from a variety of sources.(21) Some have evolved from within the system, from State legislators and other political factions increasingly informed about and wary of abuses by independent, autonomous regulatory bodies, many with parochial self-interests, and frequently without any required review of their procedures and actions by any other governing body. Basic to those attacks, however, are concerns for the program itself, for what is required for licensure or certification, for how standards are applied, and what, if anything, happens to the errant practitioner after that person has entered the system. Regardless of whether a program is statutory or voluntary, standards are standards and should be applied uniformly, and actions that are either arbitrary or capricious are taboo.

The basis for a regulatory program is threefold, encompassing education, experience, and an examination.(13) There should be an identifiable, basic educational program common to all practitioners. A fundamental core of knowledge becomes the hallmark of the science of the profession. Whether or not it can be acquired at a baccalaureate level, amplified through graduate study, or acquired in nontraditional ways or in combinations is less important than the fact that an identifiable educational base exists. Experience, on the other hand, is often of a more variable nature. Some professions have demonstrated that the skills, behaviors, and knowledge required for entry-level practitioners

can be acquired totally within the educational institution, whereas others have not. Only a studied approach to your own situation will result in that determination, but that approach should be undertaken with great care and deliberation, as I intend to discuss further in a few moments. The third component of a viable regulatory program is the examination, the availability of an instrument that allows an applicant to demonstrate possession of the behavior, skills, and knowledge needed to enter practice safely.

In at least one area in the health education field, I know that kind of instrument to be sadly lacking. In school health teaching, for example, I have been unable to find any examination to apply to persons seeking to enter that area of study and employment. In the national teacher examination series, covering, I believe, about 35 area tests, not a single test exists for health educators. A recent study by Dr. Barbara Wilks of the University of Georgia, soon to be published, (23) has identified the many areas wherein potential health educators are required to submit to examinations, but are limited to those designed for other areas, particularly physical education, with a total disregard in the process for any proven relationship, or for that matter, lack of it, between success in phys-ed examinations and school health education. Not even face-validity concepts would apply here. Interestingly, Wilks found some of these testing requirements to be State-ordered. The fact that school health educators as well as any other professionals require examinations that must be proven relevant to their specialties has not resulted in such requirements, though such constraints have been clearly set by the EEOC, the FTC, and even the U.S. Supreme Court.(9)(21)

Regardless of the profession, whether it be one where we are talking of generic or specialty practice, the examination must be relevant to the task performed by the practitioners.(3) The scoring of the examination too must be free of flaws. The best examination technique is useless if, in its design or scoring mechanism, it fails to identify potentially safe practitioners and to eliminate unsafe ones.(12)

Once these elements have been adopted as essential ingredients in the credentialing program, you must be able to demonstrate that without a doubt, those who have been credentialed and who may practice in an unprofessional manner, or prove to be incompetent despite the efforts to detect them before their credentials are initially issued, will be removed from your midst posthaste. A credentialing program is worthless if strong corrective measures to remove incompetents or others unfit to practice are missing, or even weakly enforced.

Now, let me get back to some of those basic issues I have skimmed over so far.

Without doubt, credentialing confers on its members an occupational identity. Can such an identity exist without an acceptable educational base, one generally agreed upon by all segments of the group identified? The determination of that educational base, and the establishment of a viable accreditation mechanism, are axiomatic. The fact that programs in health education are institutionally accredited is far less important, in my view, than that they lack uniform program accreditation. The very foundation on which a credentialing program in this profession should be built is a voluntary program in which a single, mutually agreed-upon agency appraises the educational offering and measures it against standards set as basic to health education, and grants accredited status to those programs if they are believed to meet those predetermined structure, process, and outcome criteria. That accredited status should be for term, not permanence, and periodic reassessment should be an integral part of the process. Certainly, to reach this fundamental goal, compromises among individuals and groups may be necessary, but you are at the point now where this can and should be accomplished. Without program accreditation, you will have no meaningful credentialing program.

The second question to address is the statutory/voluntary credentialing process. It is my firm belief that you are in a sound position now to move ahead and seek to develop a voluntary certification

program. The mood of the nation today is to limit statutory, restrictive licensing laws, to get government off the backs of the people--as I have stated, for many good reasons. Voluntary credentialing programs are the wave of the future. It is my view that independent, autonomous licensing boards, particularly those resisting some very needed basic structural changes, may be an endangered species. I find it amusing that many profess the desire for progress: It's just change they don't like. Your role delineation study should be finalized, through more and continued widespread exposure and discussion, particularly with the many special-interest groups that exist within the broad field of "health education." Here too, compromises will be necessary to achieve basic definitions regarding roles and titles, but in this sense, you are far ahead of where many other groups seeking regulation are today. Your leadership has wisely taken you into this most difficult self-assessment task at an early point, but considerable work has still to be done, and you must continue to apply measures of self-constraint and not rush ahead without careful deliberation. Unanimity can escape you easily if you're not careful, but at the very least, cohesiveness is important, particularly in such a vast, complex, and often overlapping field.

A variety of options are open to you. The first to consider is the "entry-level" credential. Should it be generic, something like "certified health educator," with specialization left to different-level certificates? If it is agreed that there is a common educational core for all health educators, a generic-level certificate may well suffice. This can be followed by specialty certificates denoting qualification in more restrictive areas of expertise, each requiring a level of skill beyond that of the beginning practitioner. Now "beyond" in this sense doesn't necessarily connote "better" or "higher," but possibly only "broader." The differences may be only horizontal. In addition to that specialty certificate may be one that denotes "excellence," and it is my belief that the consuming public is in a state of readiness now to accept a well-planned, sort of "cradle-to-grave" program. What I'm proposing to you now doesn't generally exist, though that lack is more the result of some disdain for change, a sort of "take-it-or-leave-it"

attitude, on the one hand, by some existing programs, and an earnest desire to do something different, constructive, and more meaningful than what has been done in the past by new groups such as yours, on the other hand, with progress understandably slow.

I'm particularly impressed by the basic fact that you are educators--education is your product, it is your strength. It is what you have to sell, so let's consider doing just that--educate!

What I propose you consider is, above all, a major task--it will require a lot of discussion, possible argument, compromise certainly, but you have the potential for a model for all of the health field.

First of all, re-look at your role delineation study. Is it addressing what actually is health education today, or does it address what you have decided is the ideal for health education? You can't have it both ways unless you are that rare group (which I don't believe exists) wherein the actual practices of today are those considered ideal for the field. Separate those practices found in your study that exist today and are not the ideal and identify how you intend to educate your newcomers to eliminate those and how your educational programs will require change to assure that your ideal or something near it will be reached in a reasonable time frame. Study your task analysis carefully. There's a lot of difference between a study that addresses the practice ideal and one that refers to what is happening now, or one that unknowingly mixes the two. Several professions, most notably nursing, have found that serious role discrepancies and differences in role conceptions in a task analysis can seriously affect a certification program. A 1976 study by Dr. Barbara Pieta of the University of North Florida has reflected on how holding power in a profession, among other critical things, can be markedly affected if you aren't certain about your identification as "ideal" or "actual."(10)

In your case, and at this point, consider building your certification program for the future, for what the ideal practice of health

education should be. Consider modifying the educational programs so that at whatever time frame you set, they will provide graduates with acquired knowledge, skills, and behaviors paralleling your ideal.

Within a voluntary certification program, provide for a generic certificate that signifies to anyone who is interested that this is a competent practitioner. Allow that other level, the "safe" practitioner, to a State regulatory program, if a State wants one. Offer specialty certification, in addition, to the competent certificant who wants to display special training in, let's say, school, community, or public health--or whatever other specialty you may find meaningful. Finally, at the pinnacle, consider offering a certificate of excellence denoting that the holder has given evidence of being an outstanding practitioner in the health education field, regardless of specialty.

Fundamental to this system are three elements:

The first is that each certificate be based on requirements drawn from your role delineation study, and clearly show that the certificant possesses the behaviors, skills, and knowledge essential to that level of practice.

The second is that the certificate not be granted forever, that something be expected of the certificant to guarantee that competence after initial certification will be continued. Now, in this regard I'm referring to the need for measures of continued competence.(6)(7)(19) Continuing education has failed to provide such assurances. Professor Houle(6) has characterized the continuing education movement as one "...born out of an eager directiveness and naive faith...." He has further stated that "...this mandatory continuing education phenomenon is an ever-expanding balloon that is becoming increasingly difficult to manage and on the verge of exploding." I am in complete concurrence with the view of Professor Houle and others that the "enrollment criterion" as a measure of continued competence doesn't work. A colleague of mine, in describing adjudicated cases of malpractice in the health

professions, said he knew of none in which the practitioner was found guilty as a result of a lack of knowledge.

The third element is that the entire profession embark on an ambitious public education program to inform consumers of how important it is to seek out the services of a certified practitioner. This is the major educational task I referred to when I suggested you use your educational expertise. Consumers are not as ignorant as some would like to think they are when it comes to contracting for professional services or learning how best to do that. I am a believer in Friedman's 1962(4) observation that:

> "If the argument is that we are too ignorant to judge good practitioners, all that is needed is to make the relevant information available. If, in full knowledge, we still want to go to someone who is not certified, that is our business; we cannot complain that we did not have the information."

Finally, I'd like to use a story once told by Dr. Alexander Calandra,(1) to demonstrate how easily the demand for critical thinking can lead us astray:

> It seems that Calandra some time ago received a call from a colleague who asked him to be the referee on the grading of an examination question. His colleague was about to give a student a zero for his answer to a physics question, while the student claimed he should receive a perfect score and would do so if the system were not set up against the student. The instructor and the student agreed to submit this to an impartial arbiter, and Calandra was selected. He went to his colleague's office and read the examination question, which was, "Show how it is possible to determine the height of a tall building with the aid of a barometer." The student's answer was, "Take the barometer to the top of the building, attach a long rope to it, lower the barometer to the street, and then bring it up, measuring the length of the rope. The length of the rope is the height of the building." Now, this is a very interesting answer, but should the student get credit for it? Calandra pointed out that the student really had a strong case for full credit, since he had answered the question completely and correctly. On the other hand, if full credit were given, it could well contribute to a high grade for the student in his physics

course. A high grade is supposed to certify that the student knows some physics, but the answer to the question did not confirm this. With this in mind, Calandra suggested that the student have another try at answering the question. He was not surprised that his colleague agreed to this, but was surprised that the student did.

Acting in terms of the agreement, they gave the student six minutes to answer the question, with the warning that the answer should show some knowledge of physics. At the end of five minutes, he had not written anything. Calandra asked whether he wished to give up, since he had another class to take care of, but the student said no, he was not giving up. He had many answers to this problem: He was just thinking of the best one. Calandra excused himself for interrupting him, and asked him to please go on. In the next minute, he dashed off his answer, which was: "Take the barometer to the top of the building and lean over the edge of the roof. Drop the barometer, timing its fall with a stopwatch. Then, using the formula, S = 1/2 AT squared, calculate the height of the building."

At this point, Calandra asked his colleague whether he would give up. The colleague conceded. In leaving his colleague's office, Calandra recalled that the student had said he had other answers to the problem, so he asked him what they were. "Oh, yes," said the student. "There are many ways of getting the height of a tall building with the aid of a barometer. For example, you could take the barometer out on a sunny day and measure the height of the barometer, the length of its shadow, and the length of the shadow of the building, and by the use of simple proportion, determine the height of the building." "Fine, and the others?"

"Yes," said the student. "There is a very basic measurement method that you will like. In this method, you take the barometer and begin to walk up the stairs. As you climb the stairs, you mark off the length of the barometer along the wall. You then count the number of marks, and this will give you the height of the building in barometer units. A very direct method. Of course, if you want a more sophisticated method, you can tie the barometer to the end of a string, swing it as a pendulum, and determine the value of 'G' at the street level and at the top of the building. From the difference between the two values of 'G,' the height of the building can, in principle, be calculated."

Finally he concluded, "If you don't limit me to physics solutions to this problem, there are many other answers, such as the best one. That is taking the barometer to the basement and using it to knock on the superintendent's door.